Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#17perFH,G916,67172011,WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 22^{Day} Month Physician/ 2011 $P^{\,\mathsf{M}}$ Elizabeth Brooks May 2:20 н. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Towson Baltimore 8. Date of Birth (Month, Day, Aug . 5 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🕱 F Months Hours Pennsylvania 204-28-1933 75 **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location Director 1

Yes 2 □ No N/A Maryland Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n Funeral 21209 6318 Greenspring Ave., Apt. 102 United States ral", or items? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. White "natural" 3 Divorced 4 Divorced Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. iant: If item 27 is marked other than "natur ury or other traumatic event, the Medical ury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Health Care Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Henry H. Harner Anna May Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beth Johnston / Daughter 1121 Heaps Road, Street, Maryland 21154 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. Metro Crematory Inc. | 05/24/2011 Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 299 Frederick Rd., Baltimore, Maryland 21228 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CERPBROVASCULAR ACCIDENT disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): anding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d Date of delivery ō Year 1 ☐ Yes 2 ☑ 9 ☐ Unknown detached the g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by MYELLDYSPLASTIC SYNDROME 2 No 3 Probably 4 Unknown 1 Yes should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy 1 Yes iours after death.

Interestor: After this certific filled in by the funeral director, 26. Place of Death (Check only one) or Attending Physician: 25. Was case referred to fiedical examiner? Hospital Other: 2. No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral D Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed 29b. Signature and title of certifier 29c. License number pleted cause of death (Item 23a) (Type, Print) id address of person State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Ye ar Month 8:40 **Physician** 2011 Mav Barbara Mae Busch /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Derwood Briar Meadow Assisted Living Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday 5. Social Security Number 6. Sex Days Hours Min. **Funeral** Months 1 □ M 2 X F Washington, July 5,1924 86 Director 458-40-3088 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10b. County 10a. State rai", or items 23a or 28a-f show Examinar must be notified at 1 ☐ Yes 2X No Director Oakton Fairfax Virginia 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 22124 2117 Twin Mill Lane Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Specify: White 1 □Yes 2 No Baltimore, Maryland 21215-0036 ģ 3 Widowed 4 Divorced "natural" 16b. Kind of Business/Industry untal Hygiene. ced other than "natura c event, the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) U.S. Postal Service College (1-4or 5+) Elementary/Secondary (0-12) Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be n and Mental Minnie Mae Pringle Joshua Durfee မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2117 Twin Mill Lane, Oakton, Virginia 22124 permit. Pages 1 and 2 s Department of Health ar Important: if Item 27 Is any injury or other trau once. William Busch/Husband 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sims_Chapel Cemetery May 27,201 Citronelle, Alabama 22. Name and Address of Facility 21. Signature of Funeral Service Ligensee Money & King Funeral Home, Inc Gary Downer 171 W. Maple Ave., Vienna. Va. CCO 508 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Years Congestive Heart Failure **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events as the control of the cont Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Year 3 Ectopic pregnancy Month Day in the past 12 months?
1 Yes 2 No 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed 2 **X** No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient Certification: To 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the I within 2 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature a

d title of certifier

Peter G. Hamm, MD 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

D32033

5/19/2011

5530 Wisconsin Ave., #930, Chevy Chase, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 2<u>011</u> Physician/ Month Lyle Kraus Benson, Sr. May 5:18 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Stella Maris Hospice Timonium Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 1 X M 2 □ F Days Hours July 30 **Director** 217-16-5790 89 Usual Residence of Decedent 28a-f show 10a. State 10b. County any injury or other traumatic event, the Medical Examiner must be notified at irector 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Baltimore Sparks ٥ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 13833 Thornton Mill Road 21152 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married "natural", or þ 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 🗌 Widowed 4 🗌 Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 n/a Building Inspector County Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benson Louise Kraus Carrol1 Price Jeanette 19a. Informant's Name/Relationship (Type, Print) 2011 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Sullivan Benson/Wife Box 254, Cockeysville, MD 21030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 19, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 5 Other (Specify) Atlantic Crematory 5/21/11 Glen Burnie, Maryland 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 Clar 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line ne death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Fina Onset and Death Ph_sician/ disease or condition resulting in death PROSTATE CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease of injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ate has been signed by the atte page 2 should be detached for Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ LYLE BENSON Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? this certificate 2 🗌 No Yes 1 Yes completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital: 2 **X** No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6X Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending after death Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature an 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

JACKIE JONES,

31. Date filed (Month, Day, Year,

CRNP

MD 21093

2300 DULANEY VALLEY RD.

32. Registrar's Signature

amenda # 4 Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 17, 9:45 P Curtis Lloyd Black Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Upper Chesapeake Medical Center Harford Bel Air 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth **Funeral** Aug. 12 Year) 1942 North Carolina Days 1**X** M 2 □ F Months Hours Min 246-64-0505 68 Director Usual Residence of Decedent 10b. County 28a-f short 10a State 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland |Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21085 USA 1003 Stone Court 12. Was Decedent Ever in U.S. Armed Forces?
1 XYes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. γ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 ANO Specify: Specify Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) Automobile Manufacturer Assembly Line Worker injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ပ္ Mary (nmn) Davis William (nmn) Black 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl O. Black / Spouse 1003 Stone Court, Joppa, Maryland 21085 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State ion 5 Other (Specify) Garrison Forest VA Cem. 5-26-11 Owings Mills, Maryland 4 Dona 21. Signatur f Fun 22. Name and Address of Facility McComas Funeral Home, P.A. Service Lice sée 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or complications of at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Enysician/ arrhythmia Medical Examiner cardiovascular clisease Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical pe Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d, Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Record 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 No or Attending Physician: Division of Vital To Be 25. Was case referred to medical 26. Place of Death (Check only one) examinar? Other: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending within 24 hours after death

To the Funeral Director: A
completed filled in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Gertifying Nurse Practioner: To: 29b. Signature and title of contifier 29d. Date signed (Month, Day, Year) DO05722 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bel Air, MD 21014 500 Upper Chesapeake Drive rueta 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2ďľi 4:08 Bruce Bratburd May 21 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Westminster Carroll Dove House 5. Social Security Number 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year December 25, 9. Birthplace (State or Foreign If Unde **Funeral** 7. Age (In yrs. last birthday) 1 X M 2 🗆 F 81 218-24-2826 Washington, D.C. **Director** Yrs Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Carrol1 Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4599 Griffith Road 21771 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 \(\times \) No \(195 \) Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 No 1951þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: Specify: White 3 Widowed 4 Divorced Completed 1953 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Food Clerk Grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bratburd Ruth Baumbach Eddie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 603 Bridlewreath Way, Mt. Airy, Maryland 21771 Betty Ann Bizjak /Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) MayDate 20c. Location - City or Town, State 24, 1

M Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Parklawn Memorial Park 2011 Rockville, Maryland 21. Signature of Fun al Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland M01305 20850-2805 23a. Part the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to joi as a consequence oil Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 🗌 Yes 2 🗎 No 3 🗀 Probably 4 🗗 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 No Yes 25. Was case referred to medical Certificate; To Be 26. Place of Death (Check only one) 1 Yes 2 🗗 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After 5 Pending work? Natural 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year)

ox' J

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

AUE

completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ^{Day} 2011 Doris G. Bleiberg May 22 2:55 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Yea 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🖾 F Days Min. Months Hours Pennsylvania 88 Yrs **Director** 176-14-2265 March 1, Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland | 1 Yes 2 No Montgomery Bethesda with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 5015 Battery Lane 20814 United States death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, er than "natural", or iter the Medical Examiner Armed Forces? Black, White, etc. be filed within 72 hours after d intal Hygiene. ced other than "natural", or i c event, the Medical Examin þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify: Specify: White Completed 3 Midowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Sales Representative Private Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ၉ Morris Fetters Mary Kaplan permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Bleiberg / Daughter 5015 Battery Lane, Bethesda, Maryland 20814 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cametery crematory or other place)
Baltimore
tional Cemetery 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 26, 2011 Baltimore, Maryland Signature of Fune al Servi > Lin Robert A. Fumphrey Funeral Home, Bethesda-Chevy Chase, M01619 7557 Wisconsin Avenue, Bethesda, Maryland 20814 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cerebrovascular Accident disease or condition day Medical resulting in death) Examiner Atherosclerotic Vascular Disease Sequentially list conditions, Physician/Medical Examine Due to (or as a consequence of): if any, loading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and burial-trar Due to (or as a consequence of) resulting in death) Last the attending physician the dor use as the burial IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No signed by the atte Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by I or Attending Physician: The law requires after death.

Director, After this certificate has been sign End Stage Renal Disease 1 M Yes 2 No 3 Probably 4 Unknown Vital Records, 24a. Was an . Were autopsy findings available prior to completion of cause of autopsy death? 2 🗌 No ☐ Yes 2 🔀 No 1 🗀 Yes 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 2 🛚 No Other: 1 Yes Certificate: To 1 M Inpatient 2 A ER/Outpatient 3 A DOA 4 Nursing Home 5 Residence 6 Other (Specify) of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural 5 \square Pending injury work?
1 Yes Division 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) homas Mast uson M D50534 May 22, 2011

Registrar
DHMH 17 Rev 7/2009

State

DOR

FIBER

6858 Old Dominion Drive Suite 104, McLean, Virginia 22101

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registra s Signature

Thomas Masterson,

31. Date filed (Month, Day, Year)
NAY 2 4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Sydney Frances Blackwell 3:50 A M 011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Mospital 9 Sinai Baltinone N/A Balti more 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □X Days Hours Min. 212-40-2193 08/02/1922 Maryland **Director** 88 Usual Residence of Decedent 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits r 28a-f sl notified 1 X Yes 2 □ No MD N/A Baltimore 10e, Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 901 Cherryhill Rd. Apt253 21225 U.S.A. "natural", or iten ledical Examiner n 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates. 1 Never Married 2 Married þ 1 Yes 2 No Specify: Specify: Black 3 XWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 8th Grade College (1-4 or 5+) Domestic Self Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ge 1 and 2 should be fil t of Health and Mental If item 27 is marked William Dutton Sydney Gassaway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teisha Jackson(grandchild) P.O. Box 75, Linthicum, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State <u>÷</u> ፟ δ 1 🔲 Burial 2 😾 Cremation 3 🗀 Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) on-site Crematory 05/24/11 Baltimore, 21. Signature of Funeral Service Licenses Joseph do Hes of Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between mmediate Cause (Final Onset and Death Physician/ stroke disease or condition resulting in death) Ischemic Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy ☐ Pregnant at time of death 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ stenoss arten 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law autopsy performed?

1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🔀 No Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 XInpatient 2 🗌 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending death. neral Director: A filled in by the fi Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours after within 24 hours a

To the Funeral C

completed filled Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) RES 000 MBBS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Beltimo Pandey anjari Sina Mospital S is altimore 2 401 W. Beliedus Ave 31. Date filed (Month, Day, Year) State 2 4 2011 Registrar

Block well,

Please Type or Print in Black Indelible !nk. Ensure All Copies Are Legible. Woodford Crace State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death March 14, 2011 0807 hrs **Medical Examiner** Woodford Clay Crace 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Agnes Hospital Baltimore N/A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** Foreign Country Virginia Months Days Hours Director 225-04-9188 1X M 2 F 49 Dec 11, 1961 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b County 1 X Yes 2 No s 23a or 28a-f show a notified at once, Maryland Baltimore City 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Baltimore Directo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3330 Wilkens Avenue USA Funeral 11. Marital Status 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes 2 X No 4 Divorced If Yes, Give Year 1 Yes 2 No specify: WHITE 3 Widowed Specify: ğ or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than 12th grade Construction Roofer 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Paul Crace <u>Effie Baldridge</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chawna Crace - DAUGHTER tant: If item 27 or other traums P.O. Box 455 Savage, Maryland 20763 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State Itimore, crematory or other place) Burial 2 X Cremation 3 Removal from State Donation 5 Other Specify Metro Crematory INC 03-15-2011 Baltimore Maryland 1. Sign Jure of Funeral Service Licensee Patrik Fleming 22. Name and Address of Facility Cremation Society Of Maryland 299 Frederick Road, Baltimore, MD 21228 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the disease, or complications of Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical a. Complications of Blunt Force Trauma Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical attending physician a UNPENDED AMENDED Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 虿 1 Yes 2 No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available autopsy performed prior to completion of cause of certificate has death? ✓ Yes 2 No 1 🗸 Yes Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Other Nursing Home 5 Residence 6 Other After this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day,Year) FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject fell in a shower 1 Natural FOUND: within 24 hours after death.

To the Funeral Director: A completely filled in by the ft 5 Pending 1 Yes 2 ✔ No 0740 hrs Mar 14, 2011 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 3330 Wilkins Avenue, Baltimore, MD determined (Specify) Nursing Home 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sa 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 15, 2011 el 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Victor Weedn MD JD Assistant Medical Examiner 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001 OCME 2006

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ VIST opoulo Teorac 12124 011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death zabeth 1 Unsing ente altimo n/a If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, ye Mar. 8, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🙀 M 2 🗆 F Mary land 215-24-0748 86 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 X No MD Arbutus Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21227 U.S.A. 5534 Selma Avenue "natural", or items permit. Page 1 and 2 should be filed within 72 hours after death \ Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11. Marital Status Was Deceded Armed Forces?

1 X Yes 2 No
If Yes, Give 44-52 Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify: 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Food Service Cook Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Smi thouousky Marie Thomas D. Christopoulos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 437 Elm Twin Ct., Linthicum Heights, MD 21090 Maria Fleming-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/27/11 Windsor Mill, MD Greek Orthodox 21. Signature of Funeral Service Licensee William G. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, MD 21204 1050 York Rd. Towson, 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final ₽hysician/ monio disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions cause. Enter Underlying Exami signed by the attending physician and be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year _ Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ emia 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perform ours after death.

eral Director; After this certificate I filled in by the funeral director, pag 2 🗆 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Tyes 2 🗀 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 3 23 30. Name and address of person who completed cap se of death (Item 23a) (Type, Print) . Maryland 2122 0 ens venue IMD 31. Date filed (Month, Day, Year) 32. Registrar's S State 1 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene... 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Data of Death Month 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death N/A 3104 Savoy Street Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Sex 1 M 2 □ F 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign May 3ay, Yar 936 Hours Min Months 216-30-5652 75 Yrs Maryland Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1

Yes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3104 Savoy Street 21230 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. by 1 Never Married 2 X Married 72 hours after 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: 3 Divorced 4 Divorced Specify. White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Printer Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Joseph P. Chester, Sr. Henrietta Bell permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2216 Smith Ave., Lansdowne, Maryland 21227 Brent Ridgely, Sr. / Son-in-law Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 \square Cremation 3 \square Removal from State Lorraine Park Cemetery May 23,201 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) e of Fu ral Service Licenses AMBROSEATUNERAL HOME OF LANSDOWNE 2719 Hammonds Ferry Rd., Lansdowne, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. erval Between Onset and Death Immediate Cause (Final ire Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or impute that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be execute the burial-trar Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? P Other: 1 Tes 2 × No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' 1 Yes 2 No within 24 hours after death To the Funeral Director: Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 93 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 18, Lee See-Hsien Cheng 2011 7:34 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours February 17, 1935 China **Director** 438-45-2178 76 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland 1 Yes 2 X No Montgomery N. Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10405 Quietwood Drive 20878 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: Asian 3 √ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Shih-Cheng Lee Tze-Yin Liu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hwai-Soon Cheng/Son 10405 Quietwood Drive, N. Potomac, MD 20878 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2011 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ 7557 Wisconsin Avenue Signature of Funeral Service Licenses Bethesda-Chevy Chase Inc. Bethesda, Maryland 20814. M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line nterval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ardiopulmonar Medical Due to (or as a consequence of): Examiner hour Idioventricula Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Dav Year Yes 2 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by tarkinson's Disease Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I funeral director, page 2 s autopsy perform 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation after death the Funeral Directory filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hc

To the Fune Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Or Dr Rocky, 11e William Dooley MD 20850 MD 31. Date filed (Month, Day, Year) -32. Registrar's Signature State MAY 24 Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 21, Maryon L. Cummins 2011 6:30 Ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Clifton Woods Group Home Silver Spring Montgomery Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 M 2 X F Country) Kansas 524-14-1844 89 Jan. 123, 47922 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Silver Spring Maryland Montgomery 1 Yes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 227 Springloch Road 20904 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. 1 Never Married 2 Married 9 Yes Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: Specify: White If Yes, Give 3 ☑ Widowed 4 ☐ Divorced "natural", Completed Year or Dates traumatic event, the Medical 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Company Office Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Verni L.C. Smith Katherine Hiskey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda D. Simmons/Daughter 227 Springloch Road, Silver Spring, Maryland 20904 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 s Department of H Important: If ite 20c. Location - City or Town, State Arington National Cemetery Cemetery (cemetery) 5 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20ĭ1 Arlington, Virginia Bethesda-Chevy 21. Signatur Fun I Service Licensee Robert A. Pumphrey Funeral Home/ Chase, Inc. 7557 Wisconsin Ave., Bethesda, Maryland 20814-3501 M00198 23a. Part 1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Sudden Immediate Cause (Final Ph sician/ Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Years Coronary Artery Disease Sequentially list conditions Due to for as a nonsectionne off cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami executed the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending pi IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Dav Year 2 X No g | Linknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Dementia Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Breast Neoplasm 24b. Were autopsy findings available prior to completion of cause of death? certificate has performed? Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: 2 🛛 No Other: 1 🗌 Yes မ 4 ☐ Nursing Home 5 ☐ Residence 6 M Other (Specify 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending (Month, Day, Year) 1 X Natural . 24 hours after death. • Funeral Director: Aft leted filled in by the fur 1 \square Yes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D32332 May 23, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gupta, M.D. 9801 Georgia Avenue, #2-20, Silver Spring, Maryland 20902 Suresh K. 32. Registrar State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY Рм 2:45 2011 CHALSILEEN GARNET DEEGAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death N/A BALTIMORE 626 UMBRA STREET Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 TTA 8. Date of Birth **Funeral** 1 □ M 2 1 F Months Days Hours NOV. 16 220-24-4905 82 Yrs VA Director 1928Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD. N/A BALTIMORE 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral UNITED STATES 626 UMBRA STREET 21224 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married ğ Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: WHITE Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygier 7 is marked other t CATERER 6TH CATERING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ MERVIN B. NEWMAN AMANDA ELIZABETH HINES traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THOMAS DEEGAN, SR./HUSBAND f Health a 626 UMBRA ST., BALTIMORE, MARYLAND other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SACRED HEART OF JESUS! MAY 26, 201 BALTIMORE, MARYLAND 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. of Funeral Service Licensee 6224 EASTERN AVE., BALTIMORE, MARYLAND Tart 1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head fadure. List only one cause on each line. Approximate set and Death Immediate Cause (Final Physician/ engestive disease or condition Medical resulting in death) Due to (a) as a consequence of) **Examiner** Sequentially list conditions il arry, leading to immediate cause. Enter Underlying Examir The law requires that the death certificate be executed Cause (Disease or linjury that initiated events sician and burial-trans Due to (or as a consequence of) resulting in death) Last r physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Year Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s Jas autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) 2 2 No ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Jaspital c.
4 hours after dea..
-ral Director. After ∠ Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) the Hospital 24 hours Medical

within 24 hor To the Fune completed fi

State

29a. Certifier

(Check

3 [

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month. Dav. Year)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

			Plea	ase Type or								Legibl	e.	
		For State		State	of Ma	arylan	-	artment of F		Mental Hy	giene			
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of Her of Her If item		20a. Method of Disp		3 Removal fron	n State	20b. P	lace of Dispo emetery, crer	sition (Name of natory or other plac	e)	Date	20c. Lo	cation - City	or Tov	wn, State
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mortal Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation	5 Other (Specify)		Gar		of Faith		3/2011				Maryland
permi Depar Impo any ir		21. Signature	neral Service	Licensee (low	Ken	.0	2. Name and Addres		11824 Re Reister				0ad 1136
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To the comp	2	29b. Signature and		-	, to the t	DESC OF ITTS	Mioricago,	29c. License	e number	400, 4114 440 10 11	29d. Date	e signed (M	onth, E	Day, Year)
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11-03537 UNK UNK Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month **Medical Examiner** Willie Elliott, Jr. 0311 hrs May 11, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** University Hospital N/A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign CountryMaryland Director Months Days Hours Dec. 9, 1979 1 M 217-94-6479 2 F Yrs 31 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 V Yes 2 No 28a-f show Examiner must be notified at once. N/A Pages 1 and 2 should be filed within 72 hours after death with the Maryland neat of Health and Mental Hygiene. ant: If Hem 27 is marked ather than "natural", or items 23s or 28s-f sho other tramsatic event, the Medical Examiner must be notified at once Baltimore Director 10e, Street and Number 10g, Citizen of What Country 10f. Zip Code USA 1715 Poplar Grove Street 21216 Funeral 11. Martal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14, Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married 2 No Yes 4 Divorced If Yes, Give Yeer or Dates: 3 Widowed 1 Yes 2 No specify: Specify: Black Š 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **Baltimore**, MD 21215-0036 12th Grade Private Industry Laborer 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) **Sharon Molock** Brenda Barksdale Be Willie Elliott, Sr. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15 Crooked Creek Ct. Waldorf, Md. 20602

15 Lopicar Crooked Lattitle 12, 111. 21216 19a Informan's Name/Relationship (Type, Print) **Timothy Molock**Harold Barksdale Bre ဥ Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State Department of Important: I 5/20/2011 Arbutus Memorial Park Arbutus, Maryland Donation 5 Other Specify: permit. 22. Name and Address of Facility 21. Signature of Funeral Service License Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, Maryland 21215 art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death a Multiple Gunshot Wounds Immediate Cause (Final disease <u>∤</u>xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit the Hospital or Attending Physician: The law requires that the death certificate be executed AMENDED #18,19a,perINF,G916,6/6/2011,WS Physician/Medical physician a the burial -UNPENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the attending por use as the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Š 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been s ector, page 2 should l 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? page Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other Nursing Home 5 Residence 6 Other DOA After this 1 🗸 Yes 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28d. Describe how injury occurred May 11, 2011 Subject shot within 24 hours after death.

The Funeral Director: A completely filled in by the fun 1 Natural 0230 hrs 5 Pending 1 Yes 2 ✔ No 2 ___ Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) 400 Block West Lexington Street, Baltimore, MD determined (Specify) Local Street 4 Momicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 뗭 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 11, 2011 30 Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State arka 24 Registrar OCME

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

Back)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ D. Mayonth 19, Anna Ebert 2:15 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore 8. Date of Birth (Month, Day Ye Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday, **Funeral** 9. Birthplace (State or Foreign Year) 1<u>918</u> New York 1 □ M 2 🛣 F Days Hours Months 217-20-6876 92 Yrs **Director** Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f 1 Yes 2X No Maryland Baltimore Lutherville 10e. Street and Number ms 23a or must be r 9 10f. Zip Code 10g. Citizen of What Country? Funeral 1 Atherton Garth 21093 USA r than "natural", or items the Medical Examiner mu filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ ☒ o If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify White 3 Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) State Of Maryland Secretary traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F is marked or .. Page 1 and 2 should be fil tment of Health and Mental tant; If item 27 is marked (ည Alex Durnack Kurvla 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lester Ebert (son) 2815 Woodlyn Dr., Fallston, MD other 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XX urial 2 Cremation 3 Removal from State Department o Important; If any injury or once, injury or Dulaney Valley Mem. Grdn. 05/21/1 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat 22. Name and Address of Facility Schimunek Funeral Home of Bel Ail 610 W. MacPhail Rd., Bel Air, Maryland 21014 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Jevnent disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) Exami burial-transit certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy5 Other (specify) ____ Pregnant at time of death Month Year Day the 9 Unknown Unknown by signed b Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?

1 Yes 2 No death? 1 Yes the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 1 Yes 욘 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 103014 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work death. М 1 🗌 Yes 2 🗌 No Accident Investigation within 24 hours after death

To the Funeral Director, a
completed filled in by the 72 ☐ Accider 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2011 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. Nd 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month A Physician/ Year James Martin Fitzgerald 4:50 PM 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore Examiner St. Joseph's Medical Center Towson Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 212-28-2617 1 K M 2 D F Months Days Min Month, Day Yea 79 1931 Baltimore, MD **Director** Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Maryland Towson Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? United States of America r items 23a or ner must be n 21286 Funeral 500 Virginia Avenue Apt. 507 within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. ò δ 1 Never Married 2 Married Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: "natural", Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Horse Racing Jockey other traumatic event, Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Edwin Fitzgerald Elizabeth McHale 19a. Informant's Name/Relationship (Type, Print)
Alva Marie Hilte/ sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Towson, Maryland 21286 305 E. Joppa Rd. Apt. 1808 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 2011 Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Ph sician/ SYNDROME CORONARY disease or condition PCUTE Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit BRAIN Cause (Disease or iinjury that initiated events HNOXIC Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year ☐ Pregnant at time of death ☐ Unknown signed by the at d be detached fo Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CANCER Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? Director: After this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ✓ No filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: Op the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurs tioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 05.22.2011 30. Name and address person who completed cause of death (Item 23a) (Type, Print) MALIN IN TOWSON E 7601 1 m 32. Registrar Signat State ark 2 4 2011 Registrar

Please Type or Print in Black Indelible Ink Forum All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20^{Year} Freeman Freeman John Levi May 5:30 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Manor Care Ruxton Towson 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8 Date 03 9th 1-929 . Carolina Months Days Min Hours 82 Yrs Director 242-32-7156 N. Usual Residence of Decedent f show 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? and Mental Hygiene. is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be r Funeral 7001 North Charles Street 21204 United States ge 1 and 2 should be filed within 72 hours after death it of Health and Mental Hygiene. It fifem 27 is marked other than "natural", or items or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Ś 1 Never Married 2 X Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify. **Black** 3 Widowed 4 Divorced Completed Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+ 11 Truck Driver Trucking Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Wesley Freeman Florence Jenerette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Betty D. Freeman / Wife</u> 7001 N. Charles St., Towson, Maryland 21204 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 s
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Metro Crematory Inc. 05/21/2011 Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Enysician COSO NOW disease or condition Medical resulting in death) Due to (or as a consequence of): **≻∈**xaminer nellims Diabetes Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine and I-transit nertension Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician a for use as the burial-Perighera Physician/Medical Arterial Diserve Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Month Day Year Pregnant at time of death signed by the a 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? performed?

1 Yes 2 No this certificate 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🗶 No မှ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 X Natural 5 Pending hours after death 1 🗆 Yes 2 🗌 No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 05-20-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Swite say, Toward, mas MIRPAR USLER DRIVE 31. Date filed Year) 4 2011 State 32. Registrar's Sig

DHMH 17 Rev 7/2009

Registrar

6520 1-2. Date of Death 1. Decedent's Name (First, Middle, Last) Gabriela Raquel Flores Escalante 3. Time of Death 5.05 PM **Physician** NOV 2011 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year Mar. 20, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number None 995-84-9446 7. Age (In vrs. last birthdav) Year) **Funeral** Months Days Hours 1 M 2 XF Yrs 1997 El Salvador 14 **Director** Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a, State 10b. County 10c. City, Town or Location ms 23a or 28a-f show must be notified at 1 Yes 2 No Directo Maryland Harford Edgewood 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 2120 Cedar Drive Apt. F 21040 Central America Funeral death items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc Examiner filed within 72 hours after 1 X Never Married 2 ☐ Married Yes 2**X** No altimore, Maryland 21215-0036 ō †v∑ Yes 2 □ No Specify: Latina If Yes, Give Year or Dates: ģ Specify: Salvadorian 3 Widowed 4 Divorced 'natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education other traumatic event, the Medical (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Education Student 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Health and Mental tem 27 is marked o မ David Enrique Flores Elena Patricia Rodriguez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21040 19a. Informant's Name/Relationship (Type. Print) Elena Escalante Rodriguez / 2120 Cedar Dr., Apt. F, Edgewood, Maryland Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot once, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp 5-25-2011 Towson, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Fight Washing & William STAM 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1 days Physician /Medical Due to (or as a consequence of): **Examiner** extubation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) nding physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) av Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) igned by the att I be detached fo Yes 2 □ No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 100 10001 3 Probably 4 Unknown 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Difficu 24a. Was an autopsy has 2 🗌 No 1 Tyes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner? Other: 2 No 4 🗋 Nursing Home 5 Residence 6 Other (Specify) မှ this 28a. Date of Injury (Month, Day Year) filled in by the funeral 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Attending After 5 Pending investigation 1 Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director; Afte completely filled in by the fun May May 10, 2011 O230 AM 1 28e. Plice of injury - At home, farm, street, factory, office building, etc. (Specify)

Johns Hopkins Hospite 1 Yes 2 X No Accidental extubation 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 600 North Wolfe 4 Homicide Johns Hopkins Hospital Street, Baltimore, Maryl Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Maryland 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier lliopste M.O. and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 Shilko M. D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State back Registrar 24 201

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 130 A M IN ARI) Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death Northwest Rawigiistown Hospital timare If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) T.T.A 7. Age (In vrs. last birthday) **Funeral** 1 🕅 M 2 🗆 F March Director Yrs 533-28-2240 79 Usual Residence of Decedent 28a-f shov 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 10d, Inside City Limits 1 Yes 2 No MD Baltimore Reisterstown 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? permit, Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a may injury or other traumatic event, the Medical Examiner must b once. Funeral 415 Deaconbrook Circle 21136 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates.Vietnam 1 ☐ Yes 2 🕅 No Specify: Specify: Completed 3 Widowed 4 Divorced **Black** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Electrical Engineer Coast Guard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thal Inn Freeman Wife 415 Deaconbrook Circle, Reisterstown, MD 21136 20a. Method of Disposition 20h. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, 5/20/2011 Carroll Hampstead, MD Cremation 11824 Reisterstown Road 22. Name and Address of Facility Slep Eline Funeral Home Reisterstown, MD 21136 23a. Part 1. Earler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate terval Between espit Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner una Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for sela consequence of Cause (Disease or linjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Unknown Yes 2 No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 16. betes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hyper-Knsin 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes Other: 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending iniury Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 10+1 GA Randonistown MD 54121 Vet

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 20^{Year} FRIEDMAN 19 5:50 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Days Hours Min. 0771771916 Country) Director 212-03-1612 94 MD Usual Residence of Decedent show 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE BALTIMORE 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3900 SETONHURST ROAD 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes Yes, Give within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", 3 ▼ Widowed 4 □ Divorced Completed WHITE Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Department of Health and Menti. JOSEPH GOLDMAN REBECCA COHEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUDITH KRAMER/DAUGHTER 3900 SETONHURST ROAD, BALTIMORE, MD Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State y, crematory or other place)
IE EMUNAH AITZ
M CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 05/22/2011 BALTIMORE, MD 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line, Interval Between Immediate Cause (Final cheunic Onset and Death Ph. sician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events Examir resulting in death) Last Due to (or as a consequence of): burial-Physician/Medical that the death certificate be P.O. Box 68760 phys the L as ding IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year No ed by the detached 9 Unknov Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, or Attending Physician: The law requires 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical filled in by the funeral director Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural 28d. Describe how injury occurred 5 Pending injury after death. Accident Investigation М Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Hospital within 24 hours a Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one e and title of certified 29b. Signatui 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

Date filed (Month, Day,

2 4 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MURI

32. Registrar's Signature

20 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10 reston Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Itimore 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Sex 1 M 2 □ F Months Hours Min **Director** Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland must be notified at Director 28a-f 1 ¥Yes 2 □ No MOr ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, traumatic event, the Medical Examiner Black, White, etc. Completed by ō 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates 3 ₩Widowed 4 □ Divorced "natural", 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meany injury or other traumatic event, the Meany College (54 or 5+) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crest Dr. MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Baltinois 4 Donation 5 Other (Specify) MD Name and Address of F uneral Service Licensee 21. Signatur i tlome, Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ ongestive disease or condition resulting in death) Medical Examiner ornsy arte Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Certificate: To Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Year Day g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension Division of Vital Records, 1 ☐ Yes 2 ☐ No 3X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Chronic Gidney disease 24a. Was an has performed 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 X Natural 5 Pending thin 24 hours and control of the Funeral Director Aff 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Secretifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 0 29c. License number Cecas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROESC, NO 4701 Fullerton Duenue Beltimce. Date filed (Month, Day, Year) State 2 4 2011 Registrar

DHMH 17 Rev 7/2009

11-03739 Petros Gikas Please Type or Print in Black Indelible Ink. Ensure Ali Copies Are Legible.

Petros Gikas		1- For State Registrar	tate of Maryla		epartm Certific			nd Menta	al Hyg		eg. No.	201	1552
Physicia Medical Examir		Decedent's Name (First, Midd Petros			kas		Oh. T			Date of Dea Month Vlay 18, 2	Day 011	Year	3. Time of Death 1349 hrs
		4a. Facility Name (if not instituti Johns Hopkins Hospi		mber)		41	o. City, Town, o Baltimore	r Location of	Death		4c. C	ounty of Dea	ıth
Funeral Director		5. Social Security Number 212-62-8154	6. Sex	7. Age (In	yrs. last bir	thday) Yrs.	If Under 1 Ye Months Da		24Hrs. I Min.	3. Date of Bir 08/15		Fore	irthplace (State or lign country) Greece
and show any nce.	ō	Usual Residence of Decedent 10a. State 10b. County MD n	/a	10c.	City, Town	or Locatio							10d. Inside City Limits 1 X Yes 2 No
death with the Maryland or items 23a or 28a-f shomust be notified at once	I Director	10e. Street and Number 4213 Powell	Avenue			10f. Zip Code 21206				1	_	of What Co	•
E : F	by Funeral	3 X Widowed 4 Div	larried 12. Was Dec Armed Fo 1 Yes vorced If Yes, Give Yea or Dates:	orces? 2 X	No	If Ye	Decedent of H.s., specify Cuba	n, Mexican, f	Puerto Rio	can, etc.)		White, etc.	orican Indian, Black, White
5-0036 led within 72 hours a ffygiene. other than "natura the Medical Examit	Completed	15. Decedent's Education (Spe Elementary/Secondary (0-12) 12	College (1				s Usual Occupa st of working life					estaul	•
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than	Be	George Gikas Sophia Koto						owianis					
- 25 E E	<u>٩</u>	Emmanuel Gika 20a. Method of Disposition		2	4	815	Bart Al	len La	ne,		n, M	2101	
Baltimore, permit. Pages 1 ar Department of Hec Important: If ite injury or other tr		1 X Burial 2 Cremation 4 Donation 5 Other S	necify:		0ak	Lawn	r place) me and Addres		05/2				re, MD
	_	21. Signature of Funeral Service				10	050 Yor	k Rd.,	Tow	son, M	ID 23	L204	Home, Inc.
Physician Medical Examiner		23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	on each line.	ıries consequen	ce of):	or enter the	mode of dying	, such as car	giac or re	зыгасог у апт	est, silock,	or realt	Approximate Interval Between Onset and Death
cuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											
6 be executed sysician and burial - trans	edical	UNPENDED	AMENDED										
Records, P.O. Box 68760, The law requires that the death certificate be executed toatch has been signed by the attending physician and page 2 should be detached for use as the burial - transiti	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown						ry Day Year					
· 4 4 4		Part II. Other significant condit	ions contributing to	death but r	not resulting	in the und	derlying cause	given in Part	l.			contribute to	the cause of death?
of Vital Records, P.O ag Physician: The law requires that to the this certificate has been signed by meral director, page 2 should be detained.	Completed by								_	24a, Was a autop: perfor	sy m <u>ed</u> ?		utopsy findings available completion of cause of
Vital F hysician: this certifi	옵 으	25. Was case referred to medica examiner? 1 ✓ Yes 2 No	The section is	npatient 2	ER/O	utpatient		of Death (C			Residence	6 Othe	er:
-# _^₽	Certification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury 28b. Time of Injury 1000 hrs 1 Yes 2 No Pedestrian struck by auto 28d. Describe how injury occurred Pedestrian struck by auto 28d. Describe how injury occurred Pedestrian struck by auto								Sal Boute Number City			
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: Completely filled in by the		4 Homicide dete	a not be	Local S	treet				330	or Town, Si 00 Blk. Bela	ate) ir Road ,	Baltimore	, MD
To the Hospi within 24 hour To the Funer completely fi	8	one) 2 Medicai Exa	miner: On the basis o and manner st	f examination			n, in my opinior	i, death occu					
		29b. Signature and title of certific	rasself.	is			29c. Licens			_	May 19		onth, Day, Year)
		30. Name and address of person Melissa Brassell, MD	who completed caus Assistant Med			900 W.	Baltimore S	treet, Bal	timore,	MD 2122	3		
Sta		31. Date filed (Month, Day, Year)	32. Re	gistrar's Sig	nature	Mal							

11-03727 Loretta Goode

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 15525 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar Certifica	te of Death	Reg	ı. No.	
Physici		Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
ledical Exam	iner	Loretta Ann 4a. Facility Name (if not institution, give street and number)	Goode	Month May 17, 20	11	1844 hrs
		4a. Facility Name (if not institution, give street and number) 4010 Boarman Avenue	4b. City, Town, or Location of Dear Baltimore	h	4c. County of Death	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho		s. 8. Date of Birth	(MM/DD/YYYY) 9. Birt	hplace (State or
Director		215-52-0039 1 M 2XF 60	Months Days Hours Mi		Foreig	
		Usual Residence of Decedent	113.	103 1	3 30	77
, any		10a. State 10b. County 10c. City, Town or				10d. Inside City Limits
faryland 28a-f show	b	MD NA Baltim	ore			1 X Yes 2 No
Maryl 28a-1	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Coun	try?
h the		4010 Boarman Ave	21215		U.S.A.	
eath with the Maryland items 23a or 28a-f sho ust be notified at once,	uneral	1 X Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? (§ If Yes, specify Cuban, Mexican, Puert		14. Race - Americ White, etc.	an Indian, Black,
ter dez , or i	ш	1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 No specify:		Specify: B1	ack
rurs af Itural	d by	or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. De	cedent's Usual Occupation (Give kind of	work done 1	6b. Kind of Business/Ir	
5 72 hc nn "ns	ete	Elementary/Secondary (0-12) College (1-4 or 5+)	ring most of working life. DO NOT use re	tired)		
Medi	Completed		Claims Adjuster		Insurance	Company
11215-0036 Id be filed within 72 hou fertal Hygiene. narked other than "nat event, the Medical Exa		17. Father's Name (First, Middle, Last)		e (First, Middle, Ma n Whitt:		
212 uld be Menta mark	To Be	Richard Edward Goode 19a Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street and Number or			Zin Code)
MD 21215-0036 d 2 should be filed within 7 lith and Mental Hygiene. n 27 is marked other than numatic event, the <u>Medica</u>		Tyrone Ward-Son 40	10 Boarman Ave,	Baltimo	ore, Md 2	1215
			Disposition (Name of cemetery,	Date 2	20c. Location - City or	Town, State
Pages nent of		. Statistical Serious New York State	emorial Park 5/	24/2011	Woodlawn	• Mđ
Baltimore, bermit. Pages 1 an Department of Hea Important: If ite	-	21. Signature of Funeral Service Licensee A	22. Name and Address of Facility March F/H West	21,2014	Wood Law.	
		1-00 mm 13. 11-24	4300 Wabash Ave	, Baltin	more, Md	21215
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not efailure. List only one cause on each line.	inter the mode of dying, such as cardiac	or respiratory arrest	, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Exsanguination Due to (or as a consequence of):				Death
		Sequentially list conditions, b. Erosion of Dialysis Site				
	Examiner	if any, leading to immediate Due to (or as a consequence of):				
=	хаш	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
Sox 68760, death certificate be executed to attending physician and Ifor use as the burial - transit		d.				
'60, ate be ex ohysician ne burial	Medical	UNPENDED				
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregn	ancv	23d. Date of delivery Month Da	ay Year
Box 687 e death certification and for use as the	Physician	past 12 months? Pregnant at time of death 5	Other (Specify)	1		,
be dea	hys	9 Unknown		Tan Survey		
P.O.	by	Part II. Other significant conditions contributing to death but not resulting in End stage renal disease	the underlying cause given in Part I.		cco use contribute to the 2 No 3 Proba	
	Completed	End Stage Terrai disease		24a. Was an		ppsy findings available
COF law re has be	nple			autopsy performe	prior to co	mpletion of cause of
Re : The ficate				1 Yes 2		2 No
ital ician s certi	å	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outp	26 Place of Death (Check		sidence 6 🗸 Other:	
of V g Phy fter thi	<u>ا</u>	27. Manner of Death 28a, Date of Injury 28b, Tim	e of Injury 28c. Injury at Work?	28d. Describe hov		Scene
Division of Vital Records, tal or Attending Physician: The law requirers after cleath. al Director: After this certificate has been a led in by the funeral director, page 2 should the law has the led in by the funeral director, page 2 should the law has been as led in by the funeral director.	텵	1 Natural 5 Pending FOWND: Day, Year) FOUNI	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Erosion of dia	ylsis site	
ViSi or Att fter de Direct	ij	2 Accident Investigation May 17, 2011 1842 h 3 Suicide 6 Could not be			eet and Number or Rura	Route Number, City
Di pital ours a filled	Certification:	4 Homicide determined (Specify) Townhouse / Row	house	or Town, State) 4010 Boarman Avenue, Baltimore, MD		
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director.		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death one) Addical Examination and/or investigation.				
To th withii To th	Medical	one) 2 Medical Examiner: On the basis of examination and/or inversand manner stated. 29b. Signature and title of certifier	stigation, in my opinion, death occurred a			
		As a A A CI DO A	O.C.M.E.		9d. Date signed <i>(Mont</i> //ay 18 , 2011	n, ⊔ay, Year)
		30 Name and address of person who completed arms of death (the con-	O.O.IVI.E.		viay 10, 2011	
		 Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. 	Baltimore Street, Baltimore, M	D 21223		
		31. Date filed (Month, Day, Year) 32. Registrar's Signature			·	
Regist	rar	MAY 0 1 2011 B. A back	•			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No∢ 1. Decedent's Name (First, Middle, Last) Date Month 21 2. Date of Death Physician/ May Susan K. Gottlieb 2:40 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery g. Birthplace (State or Foreign Country) New Jersey 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours Min July 18 1 M 2 X F Months Yrs. Director 135-32-4664 69 1941 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗶 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5450 Whitley Park Terrace 20814 <u>United States</u> 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 - Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Project Manager Consulting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Martin Greenspan Selma Kramer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Brazel / Daughter 12600 Rush Creek Lane, Austin, Texas 78732 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Riverside Cemetery May 25, 2011 Saddle Brook, New Jersey 21. Signature of Funeral Service Lice Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. M01530 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Breast Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 Yes 2 X No ģ Month Day Pregnant at time of death Year the g Unknown P.O. ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by s been signe should be c Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performed? 1 ☐ Yes 2 🗶 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) Hospice Hospital 1 Yes 2 X No ပ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No after death Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical ٌ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

within 2 To the I

(Check

only one 29b. Signature and

of certifi

Geoffrey Coleman,

30. Name and address of person who completed cause ϵ death (frem 23a) (Type, Print) Suite~100

Piccard

32. Registrar's Sign

Drive,

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Rockville, Maryland 20850

May 21, 2011

License numbe D37142

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

The art I is marked other than "natural", or items 23s or 28s-f show wo cheper raumatic event, the Medical Examiner must be notified at once.

Baltimore, MD 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **Shaft Sidney Hunter** 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Time of Death Physician/ Month Day May 21, 2011 0247 hrs **Medical Examiner** ter 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give Howard 95 South @ Route 32 If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6 Sex Foreign Country) Min. Days Hours 1 M 2 F 10-15-197 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No eisterstown Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 2. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Never Married 2 Married 2 Specify: Black If Yes, Give Year or Dates: 2009 1 Yes 2 No specify: 4 Divorced 3 Widowed 16b. Kind of Business/Industry ğ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired)

Physician /Medical **Examiner**

Division of Vital Records, P.O. Box 68760,

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ט	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle,	Maiden Surname)
8	Oherman S. Hunter, Ur.	Princella 1	3 ridges
0	19a. Informant's Name/Relationship (Type, Print)	dress (Street and Number or Rural Route Num	
	Princella HUNTEr/Mother 4768 St.		Planes MD 20695 20c, Location - City or Town, State
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition rematory or other p		200. Education - City of Town, State
	4 Donation 5 Other Specify:	1 Valley 5-27-201	(limonium MD
		and Address of Vacility Vavala C. G.	reene, Funeral Services
	Vauthor C. Dune 872		dallstown mo 21133
	23a. Part I. Infor the disease, or emplications that caused the death. Do not enter the m	ode of dying, such as cardiac espiratory an	rest, shock, or hear! Approximate Interval Between Onset and
	failure. Lest only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries		Death
	or condition resulting in death) Due to (or as a consequence of):		
	Sequentially list conditions, b		
ē	if any, leading to immediate Due to (or as a consequence of):		
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Medic	#16b,19b,perFH.gg	15,5/24/2011,WS	
Š	IF FEMALE: 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal of the pregnancy 2	eath 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
cian/	past 12 months?	(Specify)	
	1 Yes 2 No 9 Unknown 9 Unknown	(
Phys	Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I. 23e. Did t	obacco use contribute to the cause of death?
2		1 Ye	s 2 🗹 No 3 🗌 Probably 4 🗌 Unknown
Completed by		24a. Was	
ᄚ		auto perfe	prior to completion of cause of death?
ĕ		1 Yes	2 No 1 Yes 2 No
Be	25. Was case referred to medical examiner?	26.Place of Death (Check only one)	
0	1 Yes 2 No Inpatient 2 ER/Outpatient 3	DOA Other Nursing Home 5	Residence 6 Other Scene
=	27. Manner of Death 28a. Date of Injury (Month, Day, Year) Natural 5 Panding May 21, 2011 28b. Time of Injury 0244 hrs	Driver auto	how injury occurred a collision
뜵	1 Natural 5 Pending 2 Accident Investigation May 21, 2011 0244 hrs	1 ✓ Yes 2 No	· · · · · · · · · · · · · · · · · · ·
2	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fa	ictory, office building, etc. 28f. Location	Street and Number or Rural Route Number, Cit
er.	4 Homicide determined (Specify) Major Road / Highway	95 South @	State) Route 32, Laurel, Md.
cal Certification	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred	at the time, date and place, and due to the cau	se(s) and manner as stated.
dic	(Check only 2 Medical Examiner:On the basis of examination and/or investigation, and manner stated.	in my opinion, death occurred at the time, date	and place, and due to the cause(s)
Š	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	Que II	O.C.M.E.	May 21, 2011
	30. Name and address of person who completed cause of death (Item 23a)	1	

900 W. Baltimore Street, Baltimore, MD 21223

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar

Ana Rubio MD.

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

OCME

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2 Date of Death 3. Time of Death Physician/ 9:00A M Medical 4a. Facility Name (if not institution, give st own, or Location of Death 4c. County of Death **Examiner** TIMORE If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Director Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MORE and Number 10g. Citizen of What Country? 10f. Zip Code Funeral eride 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces Black, White, etc. ģ 1 Never Married 2 Married 1 Yes No If Yes, Give Year or Dates. Maryland 21215-0036 1 Yes No Specify 3 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Be Father's Name (First, Middle, Last Informant's Name/Relations 19b. Mailing Address (Street and Number Baltimore, Method of Disposition 20b. Place of Disposition (Name of Location - City or Town, State Date . Page 1 Burial 2 Cremation 3 Removal from State cemetery, c ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 06 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): nding physician use as the burial Physician/Medical Box 68760 use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Por Month Dav Year Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use combute to the cause of death? þ Records, 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has performed certificate 2 No 1 Yes Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Hospital 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at After 1 Natural 5 \square Pending work? n 24 hours after death.

e Funeral Director: Af oldered filled in by the fu 2 🗆 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. соmpleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -90 -23 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 75 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month May 020, 4:00 PM Katherine A. Hertz 2011 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Baltimore Towson Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8 Date of Birth Funeral 9. Birthplace (State or Foreign Months Days 1 🗆 M 2 🗶 F Hours F@Bnth 1 Pgv, Year 921 212-12-1174 Maryland Yrs Director Usual Residence of Decedent 10b. County 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f Harford Bel Air 1 Tes 2 X No 0 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral items 23a 522 Thomas Run Rd. 21015 United States death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ō 1 Never Married 2 Married Completed by filed within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: White "natural", 3 🗷 Widowed 4 🗌 Divorced Specify. the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Textiles Computer Data Entry other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers of is marked o 2 Salvatore Rose D. Piazza Page 1 and 2 should be ment of Health and Menta Caro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Mattheiss /Niece Patricia 1313 Westellen Road Towson, MD 21286 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May 23 cemetery, crematory or other place)
Chesapeake Crematory 1 Burial 2 X Cremation 3 Removal from State Beltsville, Maryland 2011 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Name and Address of Facility Funeral Alternatives 401585 Robo 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. interval Between Onset and Death Immediate Cause (Final Partly Filysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine Due to for as a consequence of if any leading to immedia cause. Enter Underlying Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 mont Pregnant at time of death the Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown peen Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy death? certificate 2 🗆 No 1 Yes Yes 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence within 24 hours after death. To the Funeral Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work 1 Yes 2 D No filled in by the Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 701 Pat 1+ move, MO 21204 auva 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MAY"18, 2011 WILLIAM CODY HIGHTOWER 3:00 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hart Heritage Estate Forest Hill Harford 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Aug. 5, 1916 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 🔀 M 2 🗆 F Yrs Kentucky **Director** 411-10-4729 Usual Residence of Decedent or 28a-f show notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a or Examiner must be Funeral USA 1318 Gunston Road 21015 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural" 3 ₩idowed 4 Divorced Specify Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Labor Union Director Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Edward (unk) Hightower Mable (unk) Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3108 Wellington Way, Baldwin, MD 21013 Patsy Scholz / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdn: 5-23-11 Bel Air, Maryland Signatury of Euneral Service Licen 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Consestive Pnysician/ JEAR disease or condition) Medical resulting in death) Due to (or as a consequence of) Examiner Physician/Medical Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Grand Live Birth 2 Live Grand Live of death Live Of Death Live Control Live Co 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No eral Director: After this certificate has been signed by the atte filled in by the funeral director, page 2 should be detached for Day Month Year 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? Yes 25. Was case referred to medical risisted Certificate: To Be 26. Place of Death (Check only one) examiner? CARA 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Hother (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie MAY 18, 2011

Registrar
DHMH 17 Rev 7/2009

State

615 W. MACPHAIL RA

32. Registrar's Signature

BULAIN MA 21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SPANEL

ALGRAD

MAY 24 2011

Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 19,2011 9:30A Doris Hawman Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 9600 Amberleigh Lane Unit F Perry Hall Balto. Social Security Number 7. Age in yrs. last birthday) If Unde 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours Min. Country)
Maryland **Director** 213-30-2067 1933 78 Usual Residence of Decedent 28a-f shov 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Md. Balto. Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9600 Amberleigh Lane Unit F 21128 USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc þ 1 Never Married 2 X Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. White Specify: Completed 3 Ulidowed 4 Divorced Year or Dates 15. Decedent's Education 16b. Kind of Business Industry
Baltimore City & 16a Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) County Schools Speech Therapist other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John C. Frisch Martha Sims 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth J. Hawman 9600 Amberleigh Lane Spouse Apt.F Perry Hall, Md. 21128 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Strial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) St. 5-25-2011 John Lutheran Sweet Air, Md. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Examir burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physiciar Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Hospital or Attending Physician: The law requires that the death for Day Pregnant at time of death the detached 9 Unknown Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

e Funeral Director: After this certificate has have filled in by the funeral director, page 2. performe Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, M. n. of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one within To the 29b. Signatur 29d. Date signed (Month, Day, Year) 123829 51

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year 510 Medical 4a. Facility Name (if not institution give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Morningside House of Friendship Hanover Anne Arundel Co. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 1/21/19 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 💢 F Days Hours Min. 93 Director 079-05-0461 /1918 Pennsylvania Usual Residence of Deceden 28a-f shov filed within 72 hours after death with the Maryland al Hyglene. d other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No MDAnne Arundel Co. Hanover 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 7548 Old Telegraph Road 21076 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 👿 Divorced Specify: Completed White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Telephone Operator Communications vrs Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out any injury or other traumatic eventone. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Stanley Laven Sophie Tricik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Robert Halter / 1319 Light Pines Court Severn, Maryland 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/24/2011 Atlantic Crematory Glen Burnie, Maryland 21. Signature of Funeral Ser 22. Name and Address of Facility Singleton Funeral & Cremation 1 2nd Ave SW; Glen Burnie, MD 21061 M01121 Services PA; 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician DRONAM disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death ate has been signed by the page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🗚 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? After this certificate 1 Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 2. No Other: 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral is 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending work? injury 2 🗌 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b_Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Townsend Hoen May 2011 3:00pm Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5 Chittenden Lane Baltimore Owings Mills 5. Social Security Number 8. Date of Birth (Month, Day, June 29 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Funeral 9. Birthplace (State or Foreign 1 X M 2 □ F Davs Hours Year Country) Yrs Director 060-30-8186 76 1934 Canada June_ Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes XX No MD Baltimore Owings Mills 10e. Street and Numbe 10g. Citizen of What Country? must be Funeral 5 Chittenden Lane 21117 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married ō þ 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 4 years President Hoen Lithography traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f Health and Mental item 27 is marked ည Thomas Irving Hoen Nancy Stocking 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maxine V. Hoen (wife) Chittenden Lane Owings Mills, MD 21117 Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō <u>∓</u> 0 1

Burial 2

Cremation 3

Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 5-23-2011 Hampstead, MD 21. Signature of Funeral Service License 22. Name and Address of Facility ELINE FUNERAL HOME 11824 Reisterstown Rd. Reisterstown, MD 21136 Wayne Osterling 23a Art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, income of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the death. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ METASTATI Ginths Medical Examiner 1ELANOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner and Due to (or as a consequence of): attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?

1 Yes 2 No Month 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HOSCUD - ATRIAL FY Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) eral Director: After thi filled in by the funeral 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIFFEZZON 515 FAIRMOUNT

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}2011 Physician/ May 9:03 a M Gary 18 Ray Hornberger Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 25 Chins Court Owings Mills Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 **X** M 2 □ F Days Hours (Month, Day, Min. **Director** Maryland 54 220-68-1748 Jan Usual Residence of Decedent or 28a-f show 10a. State Director 10d, Inside City Limits other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 1 Yes 2 X No Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Court 25 Chins 21117 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked Attack. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electrician Electrical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Hornberger Margaret Dryden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Marie Hornberger Wife 25 Chins Court Owings Mills, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 🙀 Cremation 3 🗋 Removal from State 4 Donation 5 Other (Specify) Carroll Cremation 5/21/11 Hampstead, Maryland 21. Signature of Emeral Service Licensee

22. Name and Address of Facility

11824 Reis

ELINE FUNERAL HOME Reister

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 11824 Reisterstown Road Reisterstown, Maryland 21136 Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Frontal Libe Brown molarities maly room disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 44004 melateta molonone Securities list or allies if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Pic DM Hypounceme 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of Hypertomen 24a. Was an autopsy performed? Yes 2 No death? certificate 2 No To Be 25. Was case referred to medical the funeral director. 26. Place of Death (Check only one) 1 ☐ Yes 2 🗗 No Hospital Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death. Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 5/18/2011 25002 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MANKO MD

DHMH 17 Rev 7/2009

State Registrar 750 MAINSTro

MAY 24

31. Date filed (Month, Day, Year)

21136

REISTERSTOWN

State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death Reg. No. 1. Decede ent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAG HIDEY 1245A M Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Envoy of Pikesville Pikesville 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 🛛 F Months Days Hours Jan 25, Maryland Director 212-10-4251 101 Ĩ′910 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore Randallstown 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a o Funeral 21133 U.S.A. 3843 Cassandra Road within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify Completed 3 X Widowed 4 Divorced White er than "natur , the Medical I 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha 12 Bookkeeper Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edith May Smith permit. Page 1 and 2 should be Department of Health and Men-Important: If item 27 is marke any injury or other traumatic Henry Mallonee John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randallstown, Maryalnd 21133 3843 Cassandra Road Barbara Mullinix Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 5/23/11 4 Donation 5 Other (Specify) Druid Ridge Cemetery Pikesville, Maryland 21. Signature of Fu er Il Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause Immediate Cause (Final FAILURE TO THRIVE Onset and Death Physician/ HOULI Medical resulting in death) Due to (or as a consequence of) 21/24/25 Examiner Sequentially list conditions Examine If any leading to immediate cause. Enter Underlying Cause (Disease or iinjury and that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) led by the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant 5 Other (specify) Month Day Year Pregnant at time of death Yes detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by signe 1 be a GAMERALIZED Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? + has h 24a. Was an autopsy performer page 2 1 Yes 2 No After this certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of Certificate: 28c. Injury at work?
1 Yes 28d. Describe how injury occurred injury Natural 5 Pending 2 🗌 No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) R08885Z MAY 19 2011 CAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIAMON & 2835 Smith Avenue #203 Concrimone, MANY / AND 21209 filed (Month, Day, Year) MAY 2 4 2011 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

ORIGINAL

11-03776	
Robin Lynn Hudson	

11-03776	Please Type or Print in Black Indelible Ink. Ensure All Copie	s Are Legible.
Robin Lynn Hudson	State of Maryland / Department of Health and Mental Hy 1- For State Certificate of Death	giene 2011 16537
	Registrar Certificate of Death	Reg. No.
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) Robin Lynn Hudson 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	2. Date of Death Month Day Year May 19, 2011 3. Time of Death 1804 hrs
_	Franklin Square Hospital Rosedale	4c. County of Death Baltimore County
Funeral Director	5. Social Security Number 6. Sex 17. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 217-96-4313 1 M 2XF 46 Yrs. If Under 24Hrs.	8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	MD Baltimore Baltimore	1 Yes 2 No
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Tot: If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be sofified at socator. To Be Completed by Funeral Director	10e. Street and Number 6114 Bessemer Avenue 10f. Zip Code 21224	10g. Citizen of What Country? USA
er death with , or items 23 r must be 00 Funeral	11. Marital Status 1 Never Married 2 Married 2 X No 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) White, etc.
s after ral", o	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Specify: White
136 thin 72 hours a te. than "natural edical Examin	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retired to the property of the control of the property of the prop	
21215-0036 Bid be filed within 72 hour Mental Hygiene. marked other than "natur c event, the Medical Exan TO Be Completed	12 2 Disabled	Disabled
15-00 filed win I Hygien of other t, the M	D. was in all all and	(First, Middle, Maiden Surname)
2121 ould be fil d Mental Is s marked tic event,		Marie Knight ural Route Number, City or Town, State, Zip Code)
imore, MD 2 Pages 1 and 2 shou ment of Health and N and to the traumatic or other traumatic	Robin Nixon - Daughter 6114 Bessemer Ave.	. Baltimore. MD 21224
re, I	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
Pages Pages nent o aot:]	4 Donation 5 Other Specify: Atlantic Crematory 5-	22-11 Glen Burnie, MD
Baltimore, permit. Pages 1 ar Department of He Importact: If the injory or other tr	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Br	adley-Ashton Funeral Home
	PA, 2134 Willow 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	Spring Road, 21222
Physician /Medical	failure. List only one cause on each line. Multiple Sharp Force Injuries	Retween Onset and Death
xaminer	Immediate Cause (Final disease or condition resulting in death) a. Multiple Sharp*Injuries Due to (or as a consequence of):	
ي ا	Sequentially list conditions, b.	
raminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	
10 1 E E	events resulting in death) Last Due to (or as a consequence of):	
an and all - tra	UNPENDED 10b per fh g915 5-24-11 vt #23a,ptI,perME,G919,9/22/2011,WS	
760, cate be physic he buri	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery
certification	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnar	ncy Month Day Year
Box 68760, death certificate bethe attending physicafor use as the bunysicians/Mee	1 Yes 2 No 9 Unknown 9 Unknown	
P.O.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✓ Unknown
Records, The law requires ficate has been sig s, page 2 should be		24a. Was an 24b. Were autopsy findings available prior to completion of cause of
Vital Records, system: The law requirements in securificate has been a director, page 2 should be Be Completee.		autopsy prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital Recypician: The his certificate director, page	25. Was case referred to medical 26.Place of Death (Check o	
Vita	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other 4 Nursing	Home 5 Residence 6 Other:

Division of Vi
To the Bospital or Attending Physis
within 24 hours after death.
To the Funeral Director. After this
completely filled in by the funeral dir Medical Certification: T

27. Manner of Death 1 Natural 5 Pending

28a. Date of Injury (Month, Day Year) May 19, 2011 28b. Time of Injury 1720 hrs Investigation

and manner stated.

1 Yes 2 ✔ No 28e. Place of Injury - At home, farm, street, factory, office building, etc.

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

28c. Injury at Work?

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1929 A Eastern Avenue , Essex, MD 4 V Homicide determined (Specify) Single Family Home 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

May 20, 2011

Subject assaulted

29b. Signature and title of certifier 29c. License number O.C.M.E. OCME 30. Name and address of person who completed cause of death (frem 23a)

Theodore M. King, Jr., MD

32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	for State of Mary State of Mary Registrar		irtment of Health <i>tificate of Death</i>		Jiene Reg. NO 1 1	16538
			Decedent's Name (First, Middle, Last)			2. Date of Deat	th	3. Time of Death
	Physicia Medio		Mary Emma Hale	-		May May	17, 201	1 2:50 PM
	Examin	er	4a. Facility Name (If not institution, give street and number) Glen Burnie Health & Rehabil	litation	4b. City, Town, or Location		4c. County of Dea	
	Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	If Under 1 Year If Under	er 24 Hrs. 8. Date of Birth	9. Bi	rthplace (State or Foreign
	Director			100 Yrs.	Months Days Hours	Min. (Month, Day Aug. 27	,1910 C	ountry) MD
	ind ihow at	'n	Usual Residence of Decedent 10a. State 10b. County 10	c. City, Town or Loc	ation			10d. Inside City Limits
	Maryla 28a-f s atified	Director	MD Anne Arundel	Glen Bu	urnie			1 ☐ Yes 2X No
	h the		10e. Street and Number		10f. Zip Code		10g. Citizen of What C	ountry?
	ath wit	Funeral	7355 Furnance Branch Road 11. Marital Status 12. Was Decedent Ever	in IIS 13 M	21060 Vas Decedent of Hispanic O	rigin? (Specify Yes or No-	USA 14. Race - Am	origan Indian
9	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by F	Armed Forces? 1	If	Yes, specify Cuban, Mexica	an, Puerto Rican, etc.)	Black, Whi	
8	ours af tural" al Exa		3 Widowed 4 Divorced If Yes, Give Year or Dates.		Yes 2 X No Specif	y:		hite
75	n 72 ho an "na Medio	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupation ind of work done during mo ONOT use retired)	est of working	16b. Kind of Business	s Industry
212	ed within Hygiene. other th a ent, the l		Elementary/Seconday (0-12) College (1-4 or 5+)		Unknown		Unkn	own
Maryland 21215-0036	be filed ental Hy ked oth c event	To Be	17. Father's Name (First, Middle, Last)		18. Mot	her's Name (First, Middle, M		
az Şi	should be file n and Mental h 7 is marked o raumatic eve	·	John E. Hale 19a, Informant's Name/Relationship (Type, Print)	19b Mailin	g Address (Street and Numl	Lillie M. A		in Code)
Ž	and 2 sh Health ar tem 27 is		Sandra Hale Britt (Niece)		Alston Place			
ore,	e 1 an of He If item or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispos cemetery, crem	sition (Name of atory or other place)	Date	20c. Location - City o	r Town, State
Baltimore,	tt. Pag rtment rtant: njury o		4 ☐ Donation 5 ☐ Other (Specify)		1 Cemetery	5/20/2011	Upperco,	
Bal	permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other tonce.		21. Signatury Land Service Licensee	//	Name and Address of Faci		24 Reisters sterstown,	
П			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not enter	r the mode of dying, such a	s cardiac or respiratory arre	est,	Approximate Interval Between
~~	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	Dem	ientia			Onset and Death
	Examiner		Due to (or as a co	insequence of):				0
	- +	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a co-cause. Enter Underlying	nsequence oi):				
	sate be executed physician and the burial-transit	Examiner	Cause (Disease or linjury that initiated events c	onsequence of:				
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3760	ificate ig phy as the		IF FEMALE:					
Box 68	r requires that the death certific been signed by the attending should be detached for use as	Physician/M	23b. Was decedent pregnant 23c. If yes, outcome of p	Fetal death 3			23d. Date of d	elivery Day Year
. Bo	r the air	ysic	1 Yes 2 No 4 Pregnant at tim 9 Unknown 9 Unknown	ne of death 5 □	Other (specify)		MOILLI	Day 16ai
P.0	that the ned by setace	by Pł	Part II. Other significant conditions contributing to death but n	ot resulting in the ur	nderlying cause given in Par	t I. 23e. Did to	bacco use contribute t	to the cause of death?
ds,	quires en sig	ted t	HYPERTENSION			1 🗆 Y	′es 2 No 3 □	Probably 4 Unknown
Division of Vital Records, P.O.	has be	Completed				24a. Was a autop	sy prior to	utopsy findings available completion of cause of
- R	sician: The certificate rector, pag		25. Was case referred to medical		00 Di 10			es 2 No
Vita	ysicial s certi directo	To Be	examiner? 1 □ Yes 2 No Hospital: 1 □ Inpatient	2 ER/Outpatient	Other	eath (Check only one) Nursing Home 5 Resid	ence 6 Other (Spe	ecify)
of	ng Ph fter thi ineral	ate:]	27. Manner of De th 28a. Date of injury (Month, Day, Ye	28b. Time of	28c. Injury at work?	28d. Describe ho	ow injury occurred	
sion	ttendi death stor: A / the fu	Certificate:	2/ Accident Investigation 3 Suicide 6 Could not be	At home farm stre	M 1 Yes 2		treet and Number or R	ural Poute Number
ĬĶ	al or A s after I Direc d in by		4 Homicide determined building, etc. (S)		et, factory, office	City or Town		arar noate number,
-	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of exam					
	o the Pithin 2, or the Formplet	Me	only one) 3			te and place, and due to the		s stated.
	K 3 F 8		Rain of Vaintinoin M	1. D	D 2630	I .	5/17/11	,,,,
			30. Name and address of person who completed cause of death	n (Item 23a) (Type, P	rint)		- 11111	
			RANI S. KARIPINENI 2 31. Date filed (Month, Day, Year)	02 W. T	TAPLE RD,	KINTHICUD	1, MD 21	070.
	Stat Registra		31. Date filed (Month, Day, Year)	. bak	7			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 26 per phy, 8915 5-24-11 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Henry P. Jones Month Year 5.44 PM 05 () V 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 34 E. 26th Street Baltimore
If Under 1 Year If Under 24 Hrs. N/A5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours TC M 2 ☐ F Director 425-14-4448 97 Yrs. 22, 1914 Mississippi Feb. Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show rai', or itema 23a or 28a-f ehor Examiner must be notified at 1□Yes 2□No Maryland N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ā 1770 Homestead 21218 USA Street death Funera 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify:Black 1 ☐ Yes 2 XNo Specify þ 3X Widowed 4 ☐ Divorced "naturai" Completed other than "natur 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Continental Can Co. Elementary/Secondary (0-12) College (1-4or 5+) Assembly Line Worker 8th grade Ith and Mental Hyging 127 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Robert Jones Donnie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health ar Important: If Item 27 is any injury or other trausing. 5916 Sefton Avenue Baltimore, Maryland 21224 Helen McCullough/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5/14791 为☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) East St. Peters Cem. Oxford, Mississippi 21. Signature of Funeral Se 22. Name and Address of FacilityChatman-Harris Funeral Home Jaw. 5240 Reisterstown RD Baltimore, MD 21215 23a. Part 1 Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician tro gerowe /Medical Due to (or as a consequence of): Examiner Brain Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Degeni mate Due to (or as a onsequence of): physicien a s the burial-Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a o ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 3 Probably 4 ∰Unknown certificate has been si irector, page 2 should 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes of Vital 2 1 No 1 ☐ Yes director 25. Was case referred to medical 26. Place of Death Check only one examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 中的 6 図Other (SpecifyResidence 1 ☐ Yes 2 ☐ 1No ဥ funeral 28a. Date of Injury (Month, Day Year) After t 27. Manner of Death 28b. Time of or Attending Patter death.

Director: After t Certification: 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 Tes 2 No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SWM MI) D31464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HASHMI MD 821 N. ELTAWST SHIR 308 BALTIMOREMD 21201 SHOAIB A 31. Date filed (Month, Day, Year) MAY 2 4 2011 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For Amend Item 26 State of Maryland Department of Health and Mental Hygiene Registrar Certificate of Death Reg. No. 6540 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ DUISE H. 8:15PM Jackson May 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner Sequoia Avenue Baltimore 6. Sex 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 DM 2 XE Months Hours Min Country) 621 NC. Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location the Maryland Director MD Baltimore 1 X Yes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important I firem 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be 1 any injury or other traumatic event, the Medical Examiner must be 1 Funeral Seguora USA 3307 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimone City College (1-4 or 5+) Elementary/Seconday (0-12) Teacher 12th grade 4 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Wardlaw Have Mamie Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) W. Riviera Drive Glendate Gerald Ervin/Nephen 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Battimore, MD 05/19/2011 Greamount Crematory Vaugho C. Greare Fureral Services 21. Signature of Funeral Service Licensee 22. Name and Address of Cility Read Raydall Stown MD21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or head failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ B disease or condition resulting in death) Medical s a consequence of): **Examiner** year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be 伯ルのマイスの Division of Vital Records, P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 4 Pregnant at time of death 9 Unknown the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate I 2 🗆 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 4 Nursing Home 5 Residence 6 Dotter (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Matural 5 Pending work 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5-18-2011 1061 who completed cause of death (Item 23a) (Type, Print) 30. Ame and address of persor KEISTERSTOWN PLA APAEL MERA

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Der

Jockson

phise

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#20b, c. perFH. G915, 5/24/2011, WS
State of Maryland / Department of Health and Mental Hygiene? 16541 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 5129am 12) 28/1 Leo Johnson Vernon Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner ita of Baltimore Baltimore 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔽 M 2 🗆 F Min (Month Months Hours Director 04 220-14-8362 MD or 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Johnson MD NA Baltimore 1 X Yes 2 ☐ No 0 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be Funeral 4305 Dewey Ave 21211 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black White etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. Black Specify Completed 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Vernon (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) filed within all Hygiene. 12th grade Brick Layer Construction Co. na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Page 1 and 2 should be nent of Health and Ments Edgar Johnson Ann Lee traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tra Eleanor C. Johnson-Wife 4305 Dewey Ave, Baltimore, Md 21211 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Ukn 1 Burial 2 Cremation 3 Removal from State 4 Ponation 5 Other (Specify) Garrison Forest 5/24/11 Owings Mills, MD 22. Name and Address of Facility

ARCH F/H West

4300 Wabash Ave, 21. Sign re of Funeral Service Licensee Baltimore, 21215 Md Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Pulmonary Embolus dy disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner sophageal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 this certificate has autopsy performe death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d, Describe how injury occurred After t 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check re and title of certifier 29c. License numbe RES-000 20H who completed cause of death (Item 23a) (Type, Print) Sinai Hospital of Baltimore urtis K awrence, MD 31. Date filed (Month, Day, Year) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Month Year Physician/ 10:45A.[™] M Jacob, Jr. 20 2011 James May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Co. 7904 Tressel Court Severn If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Social Security Number **Funeral** Country) Maryland Months Days Hours Min 9/6/1948ar) 1 **X**M 2 □ F δZ 214-56-4110 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits 10a, State 10c. City, Town or Location Director Anne Arundel 1 ☐ Yes 2 🕅 No MD Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7904 Tressel Court 21144 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2X Married 1 X Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2X No Specify: White Specify: "natural", Completed 3 Widowed 4 Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12State of Maryland Pretrial Investigator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked o ည Anna Steinfort James M Jacob, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Severn, MD 21144 7904 Tressel Court Mrs. Stephanie Jacob / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1. Department of I Important: If it any injury or or ö 1 ☐ Burial 2XX Cremation 3 ☐ Removal from State 5/21/2011 Glen Burnie, MD 4 Donation 5 Other (Specify) Atlantic Crematory 22. Name and Address of Facility Singleton Funeral & Cremation Funeral Signaty Licensee Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 M01220 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ rell Small Lancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examir the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death 5 Other (specify) been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) ၉ 4 Nursing Home 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer injury 1 Natural 5 Pending M Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) and address of person who completed cause of death (Item 23a) (Type, Print) 401 N. Broad way, Ballmore, MD 324-State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death $^{\text{Day}}2011$ Physician/ 11:55 P M JUDMAN MIRIAM CLARA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE GILCHRIST HOSPICE CARE TOWSON 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 92 1 ☐ M 2**X**☐ F Director 218-09-7100 1/06/1918 Usual Residence of Decedent 28a-f shov with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director notified BALTIMORE BALTIMORE 1 Tyes 2X No MD ò 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? must be items 23a Funeral 2520 FARRINGDON ROAD 21209 II.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. o þ 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 21X No Specify: Specify: "natural", 3X Widowed 4 □ Divorced Completed WHITE other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked of မ Department of Health and Mente Important: If item 27 is marked any injury or other. POMERANTZ SINOFSKY SOLOMON ADELE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SANDRA RASH / DAUGHTER 2520 FARRINGDON ROAD BALTIMORE, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 💢 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 05/23/2011 ROSEDALE, MD Donation 5 Other (Specify) SHAAREI ZION CONG. 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ e stre disease or condition 1-eins Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the k IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Live Sirth Pregnant at time of death Unknown in the past 12 months? Month Dav Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 WO 3 Probably 4 Unknown Completed nement a 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 No 1 🗌 Yes 1 Yes 2 L 25. Was case referred to medica 26. Place of Death (Check only one) Be 2 40 Other: 1 🗌 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pa 101

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 12154 PM Louis Webster Bernard Kane MAX Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death SINAI HOSPITAL OF BALTIMORE BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Days Director MD **218-28-851**0 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 □ No n/a Baltimore 10e. Street and Number 10f. Zip Code 21215 10g. Citizen of What Country? Funeral 6210 Park Heights Avenue, Unit 905 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 100 If Yes, Give 1953-55 Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ş 1 Never Married 2 X Married Specify African-American 1 Yes 2X No Specify: 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other tha any Injury or other traumatic event, the I once. Baltimore CityPublic Schools <u>Fducator</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Badie Beatrice Beverly Issac Kane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6210 Park Heights Avenue, Unit 905, Baltimore, MD 21215 Venciedora Pratt Howard Kane/Wife 20a. Method of Disposition Fintanblent 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) Arbutus Memorial Park 6-2-2011 Artutus, MD 22. Name and Address of Facility Willie Funeral Hore P.A. of Balto. Co. 21. Signat re of Funeral Service License 200 Liberty Road, Randallstown, MD 21133 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death Immediate Cause (Final HYPOXEMIC RESPIRATORY FAILURE.

Due to (or as a consequence of): Physician/ disease or condition resulting in death) Medical 2-3 days **Examiner** GI BLEED Sequentially list conditions, if any, leading to manufacture cause. Enter Underlying Cause (Disease or iinjury anding physician and use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MYPERTENSION, DIABETES, CHRONIC RENAL FAILURE 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier swat. F RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PANDEY, MD SINAI HOSPITAL OF BALTIMORE 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Eleanor 10:40AM Kenneu MAY 2011 /Medical 4a. Facility Name (# not institution, give street and number) 4c. County of Death **Examiner** AGNES BALTIMORE BALTIMORE HOSFITAL If Under 1 Year | If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year Months Days 220-22-4852 1 □ M 2 🗹 F **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ortant: if item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Medical Examinar mat be notified at 1 des 2 No Director WD Baltimire 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 515 N. Loudon Ave 21229 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married □Yes 2 No Maryland 21215-0036 1 □Yes 2 No Black 2 lf Yes, Give Year or Dates: 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Laundry 12+1 machine Operator permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item Z7 Is marked other any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Makshall Danie Mary 19b. Mailing Address (Street and Number or Renal Route Number, City or Town, State, Zip Code)
1911 MC Klan Ave. Baltimore, MD. 21217 19a. Informant's Name/Relationship (Type. Print) (Son) Henry Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5/26/11 owings mills, mo Garison Forest 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Varsha C. Greene Funeral Ser 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ANOXIC BRAIN INJUR 4 DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner EFILE TATUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical attending phi for use as the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy 5 Other (specify) P.0. by the a 1 ☐Yes 2 X No 9 Unknown as been signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate Vital 1 ☐ Yes 2 🖾 No 2 X No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA of Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: completely filled in by the f 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MO 21227 2717 FERRY PD HAMMONDS 31. Date filed (Month, Day, Year)
MAY 2 4 2011 State Registrar

DHMH 17 Rev 1/2001

11-03798	
Charles King	.lr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 0 ! ! State of Maryland / Department of Health and Mental Hygiene

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2011	0	0	1	D

		1- For State Registrar	,	Certificate	of Death		Re	g. No.	
Physici Medical Exami	an/	1. Decedent's Name (First, Middle, L	ast)	Char1	es Anthon	v King	2. Date of Death Month May 20, 20	Day Year	3. Time of Death 1705 hrs
		4a. Facility Name (if not institution, g Sinai Hospital	ive street and number)			or Location of Dea		4c. County of Deat	th
Funeral Director			Sex 7. Age (In y	yrs. last birthday	Yrs. If Under 1 Ye			1 (MM/DD/YYYY) 9. Bi Forei	
w any		Usual Residence of Decedent 10a. State 10b. County		City, Town or Lo	1//				10d. Inside City Limits 1 Yes 2 No
aryland Sa-f sho at once	Director	MD Ba/H	more K	anda	10f. Zip Code	n	10	g. Citizen of What Cou	
ith the Maryland 23a or 28a-f sho notified at once		3811 Kilburi				7/133		USA)
hours after death with the Maryland "natural", or items 23a or 28a-f she Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorce	12. Was Decedent Ever Armed Forces? 1 Yes 2		Was Decedent of H If Yes, specify Cuba Yes 2 N	an, Mexican, Puerl		14. Race - Ame White, etc. Specify: P	rican Indian, Black,
nours aff	ed by	15. Decedent's Education (Specify	only highest grade complete	d) 16a. Dece	edent's Usual Occupa	ation (Give kind of	f work done	16b. Kind of Business	/Industry
2 -	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		Detail	ler		Automi	tive
	Be Co	17. Father's Name (First, Middle, Las	Kine			Toan	ne (First, Middle, M	aiden Surname)	
D 21 should nd Mer is man	유	19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	ailing Address (Stre		Rural Route Numb	per, City or Town, State	/
nore, MD ages 1 and 2 sh and of Health and at: If item 27 is other traumat		20a. Method of Disposition unk	_	Ob. Place of Dis	sposition (Name of corr other place)		ad, Kan Bate UNK	20c. Location - City o	1, MD 21/33 r fown, State
Baltimore, permit. Pages 1 a Department of He Important: If it is injury or other t		4 Donation 5 Other Specif						Baltim	ore, mb
Bal permij Depar Impo		21. Signature of Funeral Service Lice	Sure -	2	8128 Life	ss of Facility and	and Rang	dallstown	mD 21/33
Physician /Medical		2 a. Part I. A ter the disease, or an failure. List only one cause on	each line.			-3.56	or espiratory arres		Approximate Interval Between Onset and Death
£xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Complication Due to (or as a consequent		enal Disea	ise			Death
	卢	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequent	ce of):					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen	ce of):					
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760, Teate be physicia The buri	Medical	IF FEMALE:	23c. If yes, outcome of p	_				23d. Date of deliver	у
ox 687 eath certific attending p		23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time of	of death 5	Fetal death 3 Other (Specify)	Ectopic pregn	nancy	Month	Day Year
the de	Physician	1 Yes 2 No 9 Unknow	a Curaiowu				22a Did tob	acco use contribute to	the course of death?
P.O. es that the signed by be detach		Part II. Other significant conditions Hypertensive Ca				given in Part I.			bably 4 Unknown
Division of Vital Records, P.O. Box 68 tal or Attending Physician: The law requires that the death certifing after death. **I Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as	Completed by	Hepatitis C					24a. Was ar autops	y prior to	utopsy findings available completion of cause of
tal Recc cian: The lar certificate ha	S						perform 1 ✓ Yes 2		es 2 No
Vital Rec ysician: The l his certificate l director, page	B	25. Was case referred to medical examiner?	Hospital:	EDIO TOTAL	26.Plac	Other Nursi		esidence 6 Othe	
of Vit ling Physic After this funeral dire	£	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time		ury at Work?		ow injury occurred	ir.
	ation	1 X Natural 5 Pending 2 Accident Investiga	(Month, Day,Year)		1	Yes 2 No			
Division spital or Attendir cours after death, noral Director: A	Certification:	3 Suicide 6 Could no determin		At home, farm, s	street, factory, office	building, etc.	28f. Location (St or Town, Sta		ural Route Number, City
Division To the Hospital or Attendi within 24 hours after death, To the Funeral Director: , completely filled in by the fi	Medical C	29a. Certifier 1 Certifying Physi	clan: To the best of my know er: On the basis of examination	wledge, death or on and/or invest	ccurred at the time, o	date and place, an n, death occurred	d due to the cause at the time, date a	(s) and manner as sta nd place, and due to th	ted. ne cause(s)
T. vi	Me	29b. Signature and title of certifier	anaynamilei stated.		29c. Licen			29d. Date signed (Mo	onth, Day, Year)
1 DOME		30. Name and address of person who	completed cause of death /	Item 23a)	U.C	.M.E.		May 21, 2011	
		Mary G. Ripple MD. De	eputy Chief Medical E	xaminer 9	00 W. Baltimor	e Street, Balti	more, MD 212	223	
St Regist		31. Date filed (Month, Day, Year) XX 2 4 2011	32. Registrar's Sig	parke	7				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 6 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month May 2011 Sarah Jane Konski 5:45 a^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Edenwald Baltimore Towson Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Jan 22 1929 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Hours Months Days 184-22-5708 82 **Director** Yrs Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Towson 1 🗆 Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a o Examiner must be Funeral 800 Southerly Rd. #228 21204 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", white Specify Completed 3X Widowed 4 □ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) during most of working (Give kind of work done of life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Electronics permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles Albert Scheuringer Clara Muench 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Tsottles/daughter 125 Aylesbury Rd., Timonium, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State $5/25/1^{\circ}1$ 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memoțial Gardens Timonium, MD Signature of F 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
10 W. Padonia Rd., Timonium, MD 21093 Michael /Flagle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
MONTHS Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner DEMONTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner ARKINSONS To the Hospital or Attending Physician: The law requires that the death certificate be executed the bunal-transit attending physician and for use as the bunal-tran that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 No Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DYSPHAGIA Completed 1 Yes 2 No 3 Probably 4 Unknown HYPOTHYROIDISM 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No DEPRESSION certificate 1 ☐ Yes 2 ☐ No eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending ☐ Accident ☐ Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature

Registrar DHMH 17 Rev 7/2009

State

22 WHST RO

me and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month IZ10 M 201 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 4841 Vicky Road Nottingham If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Days 1 M 2 X West Virginia 1927 Director 234-40-3373 84 Mar. Usual Residence of Decedent or 28a-f show 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
item 27 is marked other than "hatural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Maryland Baltimore Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21236 USA 4841 Vicky Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools School Bus Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harry Vaye Webb Mable Anice Letherman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4841 Vicky Road, Nottingham, MD 21236 Christa Hopkins / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If it any injury or of ó Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) Donation 5 □ Other (Specify) Lahmansville Cemetery 5—20—11 Lahmansville, WV McComas Funeral Home, P.A. 22. Name and Address of Facility 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or compli-shock, or heart failure. List only one itions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Likem disease or condition Medical resulting in death) Examiner Sequentially list conditions Due to (or if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 month Dav Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown ZWEIMEN 15 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Director: After this certificate has d in by the funeral director, page 2: performed 2 🗌 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Man r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pendina 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Direct Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) acrenso HUTBOUM 705 DIGITAL Mb 21090 FEMMINA on MUS 32. Registrar's Signatur State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 15 M Medical Facility Name (if not institution, give street and number Examiner uspice 2005 NOZ Social Security Number . Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months 1 - M 2 X 0170471932 218-26-0861 79 MD. Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits rector MD. N/A BALTIMORE X Yes 2 ☐ No Ö 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a o I Examiner must be Funera 501 S. LEHIGH STREET 21224 UNITED STATES Page 1 and 2 should be filed within 72 hours after death wern of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Deceud... Armed Forces? 1 ☐ Yes 2 X No 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ▼ No Specify: 3 X Widowed 4 Divorced Specify: WHITE Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 5TH College (1-4 or 5+) BARMAID BAR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ARTHUR WEBSTER MINNIE SEALOVER traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DORIS OLDEWURTEL/DAUGHTER 640 S. OLDHAM ST., BALTIMORE, MARYLAND item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State OAK LAWN CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 05/24/2011 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. EASTERN AVE., BALTIMORE, MARYLAND 21224 Part 1. Enter the dis shock, or heart fail se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-trar Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗆 Yes 2 🗆 No 3 🗆 Probably 4 🕽 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No Yes 25. Was case referred to medical examiner? Dent Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Xother} \) (Specify) 2 X NO မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? Accident 2 No Investigation 24 hours after deat Funeral Director: 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Mccrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of 29d. Date signed (Month, Day, Year) Name and address of person who completed 23a) (Type, Print) cause of

State Registrar

24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	S	tate of Ma	aryland		artment of F <i>rtificate of</i>		d Mental Hyg	iene		16550		
10	·		Decedent's Name (First, M.	ddle, Last)						2. Date of Dea Month		Year	3. Time of Death		
	Physici /Medic		Joseph	J.	Kutcher	•				May 19,	2011	1001	12:07 A M		
>	Examin		4a. Facility Name (If not institu		et and number)			4b. City, Town, c		eath		ounty of Deati			
		, 24€	Tate Hospice 5. Social Security Number	6. Sex	7 An	a (In vrs la	ast birthday)	Linthics	JIII If Under 24 I	Hrs. 8 Date of Birth	Anne Arundel 9. Birthplace (State or F				
	Funeral Director		218-18-2571	1 3 K3 M	2 F	87	Yrs.	Months Days		Ain. 8. Date of Birth (Month, Day Aug 13,	Year) 1923		hplace (State or Foreign untry) yland		
	land ow		Usual Residence of Decedent 10a. State 10b. Cou			10c. City	, Town or Lo	cation					10d. Inside City Limits		
	Mary F-f sh	tor	Maryland Anne	Arund	e1	Gle	n Buri	nie				1 □Yes 2 ☑ No			
	th the	Directo	10e. Street and Number					10f. Zip Code			10g. Citizer	n of What Co	untry?		
	23a	rai	326 Roosevelt	Ave.				21061				ed Stat			
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9	2 hou	ted	15. Dece	dent's Education	on		16a. Deced	ient's Usual Occup	pation		16b. Kind	of Business/			
215	5 6	Completed	(Specify only high		College (1-4or 5	5+)	life. I	kind of work done DO NOT use retire	during most of d)	working					
21	illed with Hygiene. other than	Con	12				Elec	trician					vernment		
and	ould be fil Mental H arked oth atic even	Be	17. Father's Name (First, Mide						18. Mother's	Name (First, Middle, a Svec	Maiden Su	mame)			
3	should be nd Mental marked c	ို	Joseph Kutc 19a. Informant's Name/Relati		Print)		10h Mailie	a Address (Street		r Rural Route Numbe	r City or T	our State	Zin Codel		
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Baltimore,	permit. Pag Department Important: I eny injury o		21. Signature of Fundral Serv	7	_ M	01364	K 4	Name and Address irkley-Ri 21 Crain	ess of Facility uddick Hwy . S	Funeral Ho E; Glen H	ome, I Burnie	?.A. e, MD	21061		
	in seri		23a. Part1. Enter the disease shock, or heart failure.	or complicati	ions that caused ause on each li	i the death				diac or respiratory ar			Approximate Interval Between		
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	/Medical Examiner		resulting in death)		Due to (or as										
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	ted nsit	nine	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury	≺	Due to (or as	a consequ	ence or).								
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Division	ii or Attend after death i Director: ,	Certification:		uld not be ermined	28e. Place of In building, et	jury - At ho tc. <i>(Specify</i>	me, farm, str	eet, factory, office		28f. Location (S City or Tox		√umber or Ru	ural Route Number,		
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	e Hos	Medical	(Check only 2 Medi	cal Examiner:	On the basis of and manner st	f examinat	ion and/or in	vestigation, in my	opinion, death o	occurred at the time,	date and pl	ace, and due	o to the cause(s)		
	To the Hospital or within 24 hours atterwithin 24 hours atter	Me	29b. Signature ac Hine or cer					29c. Licens	se number			-	h, Day, Year)		
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10	1		30. Name and address of per	on who comp	leted cause of	death (ttem	23a) (Type,	Print) Ku	13+0	Non	2/00	rue,	110		
	· · · · · · · · · · · · · · · · · · ·		31. Date filed (Month, Day, Y	ear)	32. F 0194	ar's Signat	TURA TURA	yver	187	xx KCho	W	eny	Suc		
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 16551 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Bernard Norman Lee, Sr. Physician/ Month Year 4:50 2 Medical 201 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/ASina: Hospital of Baltmore Baltinose If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex . Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 XM 2 🗆 F Months Days Hours Min (Month, Day, Year) 86 Yrs. **Director** 219-16-5577 2 1925 Maryland Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Baltimore Yes 2 No N/A Maryland 10f. Zip Code 21 20 9 10e. Street and Numbe 10g. Citizen of What Country? 4800 Yellowwood Ave Apt. 417 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Ves 2 No 1943 If Yes, Give Year or Dates. 1946 Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 _sBlack 1 Yes 2X No Specify: 3 ➡Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Landscaper 5th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Lee, Clara Bailey other traumatic 19a. Informant's Name/Relationship (Type, Print)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
21207
Shari Anita Hopkins/Daughter 1516 Clairidge Rd Gwynn Oak, Maryland permit. Page 1 and 2 st Department of Health an Important: If item 27 is any injury or other trau Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 6/1^{Date} 1 Cem. 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place) Owings Mills,MD Vet. Garrison Forest 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility} Chatman-Harris FuneralHome 5240 Reisterstown_{Road} Baltimore, Maryland Signature of Funeral Sarvice Licenses 23a. Part F. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest enock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Motostalic colon 4625 disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exami Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year 5 Other (specify) Pregnant at time of death 1 Yes 2 the signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a Was an Was a... autopsy performed has page 2 • Hospital or Attending Physician: The Is 24 hours after death.
• Funeral Director: After this certificate heleted filled in by the funeral director, page 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 0 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one within To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 1194043901 22 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nospital of Baltimore Sinai 2 Date filed (Month, Day, Year State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ne K a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 4b. City, Town, or Location of Death Dar Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days 1 🛛 M 2 □ F Months Hours Min 2 Yrs Director 0 Usual Residence of Decedent show 10a. State 10b. County with the Maryland 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f 1 Yes 2 No 10e. Street and Numbe ms 23a or must be n 5 10f. Zip Code 10g. Citizen of What Country? Funeral nitec permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married δ 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed hite 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ္ Dra 10 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date emetery, crematory, or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 26.00 22. Name and Address of Facility
Evans Funeral 21. Signature of Funeral Service Licensee Chapel + Cremation 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to for sela econsequence of burial-transit and Due to (or as a consequence of): attending physician I for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
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Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2011

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Registrar's

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ May 20118:55 A M Millicent Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 811 Quince Orchard Blvd. #21 Gaithersburg 9. Birthplace (State or Foreign 8. Date of Birth
(Month, Day, Ye
July 14, If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 🛱 F Months Hours New York 82 **Director** 075-22-5850 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 No Gaithersburg MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a o edical Examiner must be Funeral United States 811 Wuince Orchard Blvd. #21 20878 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify. If Yes, Give Year or Dates Specify: Black Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry than Elementary/Seconday (0-12) Finance Bookkeeper e 1 and 2 should be filed withi of Health and Mental Hygiene If item 27 is marked other th or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Evelyn ဂ္ Grant Edmund 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 811 Quince Orchard Blvd. #21, Gaithersburg, MD 20878 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. Son Christopher M. Irvis 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2XXCremation 3 Removal from State Beltsville, MD 05/23/2011 Chesapeake Crematory 4 Donation 5 Other (Specify) RANGE FAMERAL Cremation Services 933 Gist Ave.. Silver Spring, MD 20910 Gist Ave., Silver Spring, MD 23a. Part 1. Enter the diseas , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examin or Attending Physician; The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death been signed by the a should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed Yes 2 No 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Other: 4 Nursing Home 5 🗗 Residence 6 🗆 Other (Specify) Hospital: 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes ပ this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 🔀 Accident 5 Pending s after death. I Director: Af 1 Yes 2 No Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier eted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D37142 -2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rock ville MD 1355

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2011 Lucille Linsenmeyer 2:40 P.M May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Glen Burnie 304 Wellham Court Anne Arundel Co. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth
(Month, Day, Year)
March 7, 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Country) MD 1 □ M 2 X F Months Days Hours Yrs **Director** 83 220-24-7816 1928Usual Residence of Deceder 28a-f show 10a. State with the Maryland notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Glen Burnie MD Anne Arundel 1 ☐ Yes 2 🔀 No 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? pe 23a Funeral "natural", or items 23 edical Examiner must U.S.A. 304 Wellham Court 21061 filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. by 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Completed 3 X Widowed 4 Divorced Specify White Il Hygiene. other than "natura vent, the Medical E 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) uit. Page 1 and 2 should be filed within nument of Health and Mental Hygiene ortant: If item 27 is marked other thinjury or other traumatic event, the Homemaker Own Home Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ Annie Florence Carmean John Nutter Gordy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. John G. Linsenmeyer / son Glen Burnie, Maryland 21061 Department of Health Important: If item 27 any injury or other tr 304 Wellham Court, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 05/25/2011 Glen Burnie, Maryland Atlantic Crematory Signature of Funeral Service Licer 22. Name and Address of Facility Singleton Funeral & Cremation [0/357]Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Euter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 33 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to or as a consequence of: attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ate has been signed by the atte page 2 should be detached for in the past 12 months?
1 Yes 2 No Year Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform after death.

Director: After this certificate 1 Yes 2 No Yes 2 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 10 No ျပ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide
Homicide 5 Pending injury 1 Yes 2 No filled in by the Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Nar and address of pereath (Item 23a) (Type, Print) en (76 USSE

DHMH 17 Rev 7/2009

State Registrar Date filed (Month, Day,

32. Registrar's Signature

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north .	Medio		4a. Facility Name (if not	t institution, giv	e street and number)				or Location of Deat	in May		3 2011 County of Death	2:06 AM
nd	<i>)</i> 	М	Howard 5. Social Security Numb				HOSPOTO	Col	If Under 24 Hrs	<u> </u>		Howa	
	Funeral Director		143-42-6		4 🗆 4 4 6 🗆 🗗	ge (in yrs. ia 3 3	ast birthday) Yrs.	Months Days	Hours Min		rth a <i>y, Year)</i> — 19 2	9. Birth Cour	place (State or Foreign htry) Poland
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	th the I	Funeral Director	10e. Street and Number					10f. Zip Code			10g. Cit	tizen of What Cou	ntry?
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36	within 72 hours after death with the Maryland glene. ier than "natural", or items 23a or 28a-f sho er than Medical Examiner must be notified at ; the Medical Examiner		1 Never Married		Armed Forces 1 Yes 2 If Yes, Give	?		Yes, specify Cuba □ Yes 2 🙀 No	lispanic Origin? (S an, Mexican, Puer	to Rican, etc.)		Black, White,	etc.
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d 21	Hygier Hygier other t	Be C	10 17. Father's Name (First	t. Middle, Last			Hom	emaker	18 Mother's Na	me (First, Middle		n Home	
/an	d be fill dental irked c	2	Abraham (Milka		, warden	Sarramey	
Maryland	should and N is ma	1	19a. Informant's Name	e/Relationship (Type, Print)		19b. Mailing	Address (Street	and Number or Ro		er, City or	Town, State, Zip	Code)
	and 2 s Health tem 27		Roger Let 20a. Method of Disposit		Son	20b. P	6609	Swing	Court,	Clarks	vil	le, MD	21029
moğ	Page 1 tent of int; If ii			Cremation 3.	Removal from Stat	e c	emetery crem	atory or other pla	s S	26	Sout	hwest Ra	iches, FL.
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funera	al Service Licer	nsee	μισι	22.	Name and Addre	c = 1111				eral Home
	Φ□= # O		23a. Part 1, Enter the d	disease, or cor	nolications that cause	ed the death			Willow	w Sprir	ig R	oad, 21	222 Approximate
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	Medical Examiner		resulting in death)		a. Due to (or	a consequ	ience of):	7716	1,000			1	1 NSWI
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x 68	ath certif attending for use a	an/N	IF FEMALE: 23b, Was decedent pre- in the past 12 mog		23c. If yes, outcome			Ectopic pregnan	су		le:	23d. Date of deliv	
Box.	e deat the at thed fo	ysici	1 Yes 2 N 9 Unknown	lo	4 ☐ Pregnant 9 ☐ Unknown		death 5	Other (specify) _				Month	Day Year
P.O.	that the deaned by the a detached is	by Ph	Part II. Other significar	nt conditions	contributing to death	_	_		ven in Part I.	23e. Did	tobacco u	ise contribute to t	ne cause of death?
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Division	Attending or death. ector: After by the funer	Certificate:		Investigation Could not I determined	be 28e. Place of In			et, factory, office	163 2 110			d Number or Rura	Route Number,
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	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Medical	(Check 2 🔲	Medical Exam	ysician: To the best on niner: On the basis of rse Practioner: To the	examination	and/or investig	ation, in my opini	on, death occurred	at the time, date	and place,	, and due to the ca	use(s) and manner stated.
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)			30. Name and address	of person who	Completed cause of	death (Item	23a) (Type, Pri	nt) Edn	a Ri Iunbi	14:11, h	10	2104	14
	Stat Registra		31. Date filed (Month, D		32. Regist	rar's Signat	park	1	1699 a R, lun-bi	-			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 7,8 per fh / g916 6-1-11 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 4a. Facility Name (if not institution, give street and number) Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death nds Funeral 8. Date of Birth 1914 9. Birthplace (State or Foreign 1 🗆 M 2 🗓 F 97 Months Davs Hours Min 01/13/119 Country) Director 219-36-0694 POLAND Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD BALTIMORE OWINGS MILLS 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4730 ATRIUM COURT, #374 21117 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No
If Yes, Give Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) TECHNICIAN BELVEDERE PATHOLOGY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) NATHANIEL HERLICH MALKA WISHNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SIDNEY KROME / SON 6 GLYNDON COURT REISTERSTOWN, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date MARYLAND FREE STATE 1X Burial 2 Cremation 3 Removal from State 05/23/2011 ROSEDALE, MD 4 Donation 5 Other (Specify) 21, Sign 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part 1. Latter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due lo (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Examiner Displits for as a cryoseconomic of The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day Year Yes 2 No ate has been signed by the page 2 should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ️ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy after death.

Director: After this certificate I performed 1 Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) ၉ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 4 2011 State Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-= State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number, Examiner 4c County of Death . Age (In yrs. last birthday Date of Birth Birthplace (State or Foreign **Funeral** 1 □ M 2 □**X**F Months 0272271922 Director 219-21-8454 89 UKRAINE Usual Residence of Decedent Show 10a. State 10b. County orrant; и ием 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD N/A BALTIMORE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 6918 MARSUE DRIVE, APT. 1D 21215 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🛣 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify: 3 □XWidowed 4 □ Divorced Completed Year or Dates WHITE Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ BERNSTEIN TSRAFI RAHIL UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RAISA SHTEYNBERG/DAUGHTER 8005-C GREENSPRING WAY, OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/22/2011 BALTIMORE, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. . E 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ Vas disease or condition Medical resulting in death) as a consequence of) Examiner Sequentially list conditions Examiner Due to (or as a sonsequence or). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check within 2 To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 15 ath (Item 23a) (Type, Print) 90 6 State 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011

			For State Registrar	State of Ma	ryland / Dep Ce	rtificate of L			Reg. No.	0	16558		
	Physicia	n/	Decedent's Name (First, Middle, Las	t)	<u> </u>			2. Date of Dea Month	Day	Year	3. Time of Death		
	Medic Examin	al	Agnes Morse 4a. Facility Name (if not institution, give	street and number)		4b City Town or	Location of Death	MAY		2011 nty of Death	7.00 P M		
	CXAIIIII	eı	ST. AGNES	HOSPITA	AL		TIMOR	E	40.000	N/			
	Funeral Director		5. Social Security Number 219–30–0880 6. S	ex ☐ M 2 M F 7. Age	(In yrs. last birthday) 93 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h / 1917	9. Birth Co <i>ul</i>	place (State or Foreign ntry)Virginia		
	ryland -f show ied at	ctor	Usual Residence of Decedent 10a. State 10b. County MD N/	7	10c. City, Town or Lo						10d. Inside City Limits 1 ☑ Yes 2 ☐ No		
	he Ma or 28a s notif	Dire	10e. Street and Number	A	parchiore	10f. Zip Code			10g. Citizen	of What Cou			
	s 23a ust be	eral	3411 Dudley Avenu	e			21213			USA			
9500-612	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The Apple and Mental Hygiene. The Apple and Mental Hygiene is a strong strong strong strong other traumatic event, the Medical Examiner must be notified at	ed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 IN If Yes, Give Year or Dates.	lo I	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		ecify Yes or No- Rican, etc.)	В	lace - Ameri lack, White, ify: Bla	etc.		
ဂ ဂ	2 hour "natu edical	Completed	15. Decedent's E (Specify only highest gra	ducation		edent's Usual Occup		ing	16b. Kind of	Business Ir	ndustry		
[7]	ithin 7 iene. r than the M	Com	Elementary/Seconday (0-12)	2 Years	ife. [OO NOT use retired) Factory	Worker		Cloth	ning F	actory		
ם	filed w al Hyg d othe svent,) Be	17. Father's Name (First, Middle, Last)		<u> </u>		18. Mother's Nam	e (First, Middle,	Maiden Surna	ıme)			
ryland	uld be d Ment marke natic	្ន	Algie H. Mays	0:0			Henrietta						
Mar	d 2 sho alth an 27 is i		19a. Informant's Name/Relationship (T) Shani Morse - Gra		مممما	ing Address (Street a Dudley A							
baltimore,	Page 1 and nent of Hea ant: If item ary or othe		20a. Method of Disposition 1 M Burial 2 Cremation 3 4 Donation 5 Other (Specif	Removal from State	20b. Place of Disponentery, cre	osition (Name of matory or other place emorial Pa	e) :	Date /2011	20c. Location		own, State ry.land		
Balt	permit. Page 1 a Department of I Important; If ite any injury or of		21. Signature of Funeral Service Licens	lan-		2. Name and Addres	U.E	atman Har more, Mar			me -		
P	hysician/	N 3	23a. Part 1. Enter the disease, or com shock, or heart failure. List only o Immediate Cause (Final disease or condition	plications that caused ne cause on each line.	the death. Do not ent	ter the mode of dyin	g, such as cardiac o	or respiratory arr	est,		Approximate Interval Between Onset and Death		
	Medical Examiner		resulting in death)	*	consequence of):	I DAI	FUMO	1/ 🛆			2 DAYS		
V.	n #	niner	if any, leading to immediate Due to (or as a consequence of):										
\$	xecuter r and al-trans	Exan	Cause (Disease or iinjury that initiated events resulting in death) Last	Ų. <u> </u>	STROKE consequence of):	=					INKNOWN		
9	icate be executed physician and s the burial-transit	edical Examiner	· ·	d									
700 X00	To the thospital or Attending Priysician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Σ∣	in the past 12 months? 1 Yes 2 No	23c. If yes, outcome o 1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnand ☐ Other (specify)	у			Date of deliv	very Day Year		
5	at the d by the detache	Phy	9 ☐ Unknown Part II. Other significant conditions or		t not resulting in the	underlying cause giv	ren in Part I.	23e Did to	bacco use co	entribute to t	he cause of death?		
ı, ı	ures tr	ed by	DEMENTIA								bably 4 Unknown		
Records,	ne iaw req te has bee age 2 sho	omplet	CHRONIC KI DIABETES	DNEY	DISE	ASE		24a. Was a autop	rmed?	b. Were auto prior to co death? 1 \(\sum \) Yes	opsy findings available ompletion of cause of		
אונשו ב	ertifica ctor, p		25. Was case referred to medical examiner?				ace of Death (Check		2 No	i Li fes	Z L NO		
> 1	rnysic this or	유	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatier 28a. Date of injury	nt 2 ER/Outpatie		4 ☐ Nursing Ho	me 5 Resid			y)		
- -	ath. ath. r: After re fune	icate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day,		work	? Yes 2 🗆 No	zod. Describe in	ow injury occi	uneu			
	tal or Atters The safter de al Directo ed in by the	l Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, sti (Specify)	reet, factory, office		28f. Location (S City or Tow		nber or Rura	l Route Number,		
	ine rrospi iin 24 hou the Funer ipleted fill	Medical	(Check 2 Medical Exami	iclan: To the best of mer: On the basis of exa e Practioner: To the b	amination and/or inves	stigation, in my opinic	in, death occurred at	the time, date a	nd place, and	due to the ca	ause(s) and manner stated.		
	To the		29b. Signature and title of certifier	Katss	Ku. M	29c, License	number 23747		29d. Date sign	ned (Month,	Day, Year)		
	3		30. Name and address of person who o			Print)							
	Stat	e_	KATHELINE KA 31. Date filed (Month, Day, Year)	TSRIKU 32 Aegistrar	900 's Signatu	CATON	AVENUE	= BA	Trmo	DRE	UD 21229		
	Registra		MAY 2 4 20	99 /	, A. D.	arte							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-03781 State of Maryland / Department of Health and Mental Hygiene Jamile Macajous 1- For State Certificate of Death Reg. No. Registrar 2, Date of Death 1. Decedent's Name (First, Middle,Last) Macajous Physician/ Month Day May 20, 2011 0558 hrs Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Johns Hopkins Hospital If Under 1 Year If Under 24Hrs. 8, Date of Birth(MM/DD/YYYY) 9, Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Hours Months Director Country) 19-89-784 1 M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County in y 1 Yes 2 No item 27 is marked other than "natural", or items 23a or 28a-f show traumatic eveot, the Medical Examiner must be notified at 90cc. MA Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married Yes If Yes, Give Yaar or Dates: 1 Yes 2 No specify: 3 Widowed 4 Divorced hours after Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic evect, the Medical Examiner. á 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be IDUX am irra 19a. Informant's Na E/Relationship (Type, Prin) Mother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ို amirra 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State emeters 4 Donation 5 Other Specify Russ 21. Signature of Funeral Service Lib insec uneral Home, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical a Sudden unexplained death in infancy Immediate Cause (Final disease *≛*xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician and be detached for use as the burial - transi Physician/Medical AMENDED 23a, 27, 28a-f, per me, g917 7-25-11 sm X UNPENDED Hospital or Atteodiog Physiciao: The law requires that the death certificate be 24 hours after death. Box 68760, IF FEMALE: 23d. Date of delivery 23c, If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death Year 3 Ectopic pregnancy Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. á 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been sector, page 2 should 24b. Were autopsy findings available 24a. Was an autopsy death? Yes 2 No 2 No 1 🗸 Yes 26.Place of Death (Check only one) director, 25. Was case referred to medical æ examiner? Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other 2 FR/Outpatient 3 DOA this 1 🗸 Yes ၉ 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 28a. Date of Injury To the Hospital or Atteodie within 24 hours after death.

To the Fuoeral Director: ? 1 Natural 1 Yes 2 X No Unknown Division 5 Pending fd 5:00 am fd 5-20-11 by the 2 ___ Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State 402 N. East Ave 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be determined (Specify) found at residence Baltimore,Md. Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedlcar Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cer May 21, 2011 O.C.M.E. 30. Name and eddress of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001 OCME 2006

State Registr<u>ar</u> Mary G. Ripple MD.

32. Regist ar's Signature

Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ishinia Miller		State of Maryland / Department of Health and Mental Hygiene 1-For State Certificate of Death	11 1656
Physici	ian/	Registrat 1 December S Name (First Middle Last) 2 Data of Death	3. Time of Death
ledical Exam			2254 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Hospital Baltimore	Death U/A
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) Months Days Hours Min.	9. Birthplace (State or Foreign MARVI ALI
Director		215-39-9101 1 M 24F 1/ Yrs. Dune 21, 1943	Foreign MARYLAND
any .		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	 	Md N/A Baltimore	1 Yes 2 No
Maryla 28a-f	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of Wha	at Country?
death with the Maryland or items 23s or 28s-f sho must be notified at once			15
eath wi	Funeral	11. Marjiel Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race- White,	American Indian, Black, etc.
after d al", or	by F.	3 Widowed 4 Divorced lift Yes Give Year 4 Vee 3 M Ne needs:	3lack
hours natur Exami			iness/Industry
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygier and a smart of Health and Mental Hygier than "matural", or items 23a or 23a-f the nari. If item 27 is marked other than "matural", or items 23a or 23a-f the nor other traumatic event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Enforcement Corp Enviro	nmental
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica			1
D 21215-00; should be filed with and Mental Hygiene 7 is marked other t	o Be		1
AD 2 2 shoul h and N 27 is m	To.	Maria Boyd (mother) 1302 North Fremont Ave Baltimore.	Mary and
Baltimore, MC permit. Pages 1 and 2 s Department of Health as Important: If item 27 injury or other traum		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location 70 crematory or other place)	City or Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		4 Donation 5 Other Specific King Memona May 28 2011 Wood 10	awn, Maryland
Balti permit, Departu Importi injury		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23. Name and Address of Facility 24. Name and Address of Facility 25. Name and Address of Facility 26. Name and Address of Facility 27. Name and Address of Facility	al Service PiA
Physician		23a. Part I. Enter the disease, promplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart	
/Medical		failure, List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries	Between Onset and Death
-		or condition resulting in death) Due to (or as a consequence of):	
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	
-	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
Sox 68760, death certificate be executed the executed the extending physician and I for use as the burial - transi	al E	dd	
50, te be ex ysician burial	edical	UNPENDED AMENDED	
ox 6876 eath certificate attending phy for use as the	an/N	FFEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?	elivery Day Year
Box 68760, c death certificate be the attending physicied for use as the buri	Physician/N	4	
the the			ite to the cause of death?
- s .50 e	ed by	1 Yes 2 No 3	Probably 4 Unknown
of Vital Records, ag Physician: The law requin ther this certificate has been someral director, page 2 should the state of	Completed	24a. Was an 24b. We autopsy pric	ere autopsy findings available or to completion of cause of
Rec The I ficate I	S	performed? dea 1 ✓ Yes 2 No 1	ath? Yes 2 No
Vital ysician his certi director	Be		Other:
of Vi ing Physi After this	2	27 Manner of Double	
Sion Attendi death. ctor: /	atio	1 Natural 5 Pending May 19, 20 1 ear) 2100 hrs 1 Yes 2 № No Passenger auto collision	
Division tal or Attendin ts after death. al Director: A	Certification:	3 Suicide 6 Could not be determined Could not be determined (Specify) Major Road / Highway 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 1900 Block of Bel Air Road, B.	
Hospit 24 hour Funcri			
Division of To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due and manner stated.	to the cause(s)
	Ž		(Month, Day, Year)
3 2m		30. Name and address of person who completed cause of death (Item 23a)	I
		Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
	ate	103 31 V 13 /1 '7113 7 1 /2) 100 100 200 Ala A. A. A.	
Regist	LE L	min of real Marie les blances	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month May Regina Myers 2^{Day} Μ. 2011 12:40 Pm Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death
Baltimore **Examiner** Lutherville 200 Belmont Forest Court, Apt. 206 If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 □ M 2 🂢 Hours Min NOV. 1944 Maryland 217-40-8573 **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Lutherville 1 ☐ Yes 2 No Baltimore Maryland 10e. Street and Number 10f. Zip Code Ь 10g. Citizen of What Country? 206 er than "natural", or items 23a or the Medical Examiner must be Funeral 21093 U.S.A. Apt. 200 Belmont Forest Court, within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Black, White, etc. þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Keller Breighner Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,21093$ 200 Belmont Forest Court, #206 Lutherville, MD Charles E. Myers, Jr. Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 5-27-2011 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem Baltimore Maryland 21. Si va ure of Fareral 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21204 Towson, Maryland 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ uni disease or condition Cancar) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). burial-transit Dause (Disease or imputhat initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 Yes 2 No Por Month Day Year Pregnant at time of death been signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? **^** Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed? Yes 2 No To the representation of the function of the f 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 No မှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending 1 Yes 2 No Accident 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Tertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c License number 29d, Date signed (Month, Day, Year) 5/23/11

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark R. Stromberg MD 1734 YORK Rd Lutherville, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 Delphine M. Mickens 12:10 p. M May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Windsor Mill 7127 Bexhill Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2**X** F Country) **Director** 216-50-2314 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No Windsor Mill MD **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21244 USA 7127 Bexhill Road Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Maryland 21215-0036 1 Yes 2 No African-American 3 Widowed 4 ☐ Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Union Bethel HeadStart Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeper Center other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Menta Mildred Lewis Nelson Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .8 1 and 2 s of Health a item 27 7127 Bexhill Road, Windsor Mill, MD 21244 Kimberly Mickens/ Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State permit, Page 1 and Department of Hamportant; If ite 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ō 5-25-2011 Woodlawn, MD injury (Donation 5 Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility Wile Funeral Home P.A. of Faltimore Co. 9200 Liberty Road, Randallstown, MD 211.33 23a. Part 1 Inter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ N emenTIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or imjury that initiated events and-trans Due to (or as a consequence of): resulting in death) Last bunal-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be attending physic I for use as the b Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

Q Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Day 1 Yes 2 No signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 10 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy page this certificate 1 Yes 2 Wo Yes 2 1100 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No 1 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 😾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 510 Name and address of person who completed cause of death (Item 23a) (Type, Print) SQUI NOVIH EHAVLE DON W.1)

DHMH 17 Rev 7/2009

State

Registrar

4

Lorraine Joyce Mitchell

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 16563

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	State of Maryland / Department of He	ealth and Mental Hygiene

		1- For State Registrar				Certific	cate of	Death					Reg. No)			
Physici		Decedent's Name (First, Midd	le,Last)							2.	Date of De	ath Day	Yea	_	3. Time o	
Medical Exam	iner	TOTTGETTE OUTCE										May 19,				1813	hrs
		4a. Facility Name (if not institution 1829 Tayer Road	_				4	b. City, Town Aberdee		ocation of	Death			lc. County of Harford	f Death		
Funeral		5. Social Security Number	6. Se	x	7. Age (I	n yrs. last bir	rthday)	If Under 1		If Under		8. Date of Birth (MM/DD/YYYY) 9.					ate or
Director		215-34-1013	1	м 2 <u>X</u> F		76	Yrs.	Months	Days	Hours	Min.	Nov.	16,	1934	Foreig Cou	n Intry) Mã	aryland
ow any		Usual Residence of Decedent 10a. State 10b. County Maryland Har			10	c. City, Towr	or Location	on	n 10d. Inside City Limits 1 Yes 2 X No								
yland P-f sh	tor	Maryland Har	TOL	u		Aber	.deen	10f. Zip Cod	lo				10a Ci	at Cour			
th the Maryland 23a or 28a-f sho notified at once	Funeral Director	1829 Tower Roa	a					210					_	JSA	at Cour	uy r	
h with 1 ems 231	eral	11. Marital Status 1 Never Married 2 M		12. Was Dec		er in U.S.		'as Decedent of Hispanic Origin? (Specify Yes or N Yes, specify Cuban, Mexican, Puerto Rican, etc.)						14. Race White		can Indian	, Black,
hours after death with the Maryland natural", or items 23a or 28a-f sho Examiner must be notified at once				1 Yes	2 X	No		Yes 2 X				,		Specify:		ite	
nurs ad Itural	d by	15. Decedent's Education (Spe	cify on	or Dates: ly highest grad	de comple	eted) 16a.		's Usual Occi					16b.	Kind of Bu	siness/li	ndustry	
64 3 🖃	Completed	Elementary/Secondary (0-12)	\top	College (1	-4 or 5+)		during mo	st of working	life. D	O NOT us	se retired	1)		Auto	mot	ive	
0036 within 72 jiene. ser than "	ם	12					Assen	bler						Manu	fac	turir	ng
Filed v. Hygi		17. Father's Name (First, Middle										irst, Middle,					
21215-0036 vald be filed within 7 Mental Hygiene. marked other than	o Be	Phillip Ernes 19a. Informant's Name/Relations	t D	eigert		110	h Mailine	Address (S		Elsi	e Agi	usta I	Rott	City or Town	State	7in Codo	
O % 5 % 3	우	Howard Lee Mi						Tower						-			,
ore, MI ss 1 and 2 s of Health as If item 27		20a. Method of Disposition				20b. Place	of Disposit	ion (Name of				Date		Location -			te
DOF ages 1 at of F t: If i		1 Burial 2 Cremation		Removal fr	om State		tory or oth		O.		E /2:	1/11		las en en	3.6	etitida -	3
Baltimore, permit. Pages 1 a Department of He Important: If ite	-10	4 Donation 5 Other Si 21. Signature of Funeral Service				HITTE		ervice				4/11 McComa		owsor.			
Depr.	10	Tath (oon)	0)	antiu	200	<u>ن</u>		317 Col		•							
Physician		23a. art I. Enter the disease, or failure. List only one cause	compli	ications that c	aused the	death. Do n										Approxi	mate Interval
/Medical Examiner		Immediate Cause (Final disease		Hyperte	ensiv	e Athe	erosc	leroti	c (Cardi	ovas	cular	Di	sease			Death
(or condition resulting in death)		oue to (or as a													
	<u>~</u>	Sequentially list conditions, if any, leading to immediate	ь	Oue to (or as a	conseque	ence of):										-	<u> </u>
	틭	cause. Enter Underlying Cause (Disease or injury that initiated	С														
ecuted and transit	Examiner	events resulting in death) Last	d.	Due to (or as a	conseque	ence of):											
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760, ficate bo g physic the bur	§	IF FEMALE: 23b. Was decedent pregnant in the	ie	23c. If yes, o	outcome o	of pregnancy	,						2:	3d. Date of			V
certification of the certifica	Sia	past 12 months?				e of death		al death er (Specify)	3	JECTOPIC P	pregnanc	У		Month	L	ay	Year
Box 68 death certif the attending of for use as	Physiciar	1 Yes 2 No 9 Uni	nown	9 Unkno	own		о <u>г</u> Оп	er (opeany)				_					
P.O. Box 68 es that the death certified by the attending speed by the attending seed detached for use as	by P	Part II. Other significant condit	ions	contributing to	death bu	it not resultin	ng in the ur	nderlying cau	se giv	en in Part	l.			use contri	_		_
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Reco	Completed											perf 1 ✓ Yes	ormed?		eath? Ye	s 2	2 No
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medica examiner?	_					26.PI		Death (C	heck onl	y one)					
Vitis of this of the last of t		1 ✓ Yes 2 No	H				outpatient					lome 5				Scene	
Division of Vital Records, P.O. Box 68760, talor Attending Physician: The law requires that the death certificate be rs after death. al Director: After this certificate has been signed by the attending physiciled in by the funeral director, page 2 should be detached for use as the buri	E	27. Manner of Death 1 X Natural 5 Pend	lina	28a, Date (Month	of Injury , Day,Year)	28b.	Time of In	`		at Work? s 2 □ N	- 1	3d. Describe	how in	jury occurre	ed		
SiOr Attendary cetor: by the	cati	2 Accident Inves	stigatio		e of Injune	At home f	arm etroot	, factory, offic				of Location	Street	and Numbe	r or Pu	al Poute l	Number, City
Divis pital or At ours after d teral Direc filled in by	Certification:	dete	d not b mined	e	e or injury	- At Hoffie, I	aiii, sireei	, ractory, orm	Je Dun	ullig, etc.	20	or Town,		and Number	i oi Rui	al Route i	dunber, only
Tospid 4 hour 7 uner	-	29a. Certifier 1 Certifying Pi	rvsicia	n: To the bes	t of my kn	nowledge de	ath occum	ed at the time	date	and place	and du	e to the cau	ise(s) a	nd manner	as state	ed	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical	(ondon only	miner:	On the basis of and manner s	of examina												
F 2 2 8	ž	29b. Signature and title of certifie		and manner s	tateu.	·		29c. Lic	ense r	number			29d	Date signe	d (Mor	th, Day, Y	ear)
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VY		30. Name and address of person	who co	4													
pira		Theodore M. King, Jr.	MD.			ical Exam	niner 9	00 W. Ba	ltimo	re Stree	et, Balt	imore, M	D 21	223			
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P.O. Records, Division of Vital

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5 Thomas James Meredith Sr. 10:22 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rosedale Hmore HOSPITA /uare 8. Date of Birth (Month, Day, Year) Feb. 1, 1942 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Hours Country)
West 218 40 2509 69 Director Virginia Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f must be notified Maryland Baltimore Essex 1 Yes 2 X No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1739 Eastern Boulevard 21221 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give 1959/6 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian o. 1 Never Married 2 X Married ğ 1 X Yes 2 □ No If Yes, Give 1959/63 Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural" 3 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Investor Real Estate 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) James Clark Meredith Mary F. Gerken 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1739 Eastern Boulevard Baltimore, Maryland 21221 Wendy Meredith (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗔 Removal from State Gardens Of Faith Cemetery 5/25/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue ESSEX Maryland 21221 23a. Art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ ardiopulmonary disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner brain Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of ulseless electric that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical that the death certificate be Metasta use as the IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ for in the past 12 months? Month Pregnant at time of death 2 No the g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 pe 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Yes 2 No 1 Yes 2 WNo or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\sum \) No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After I
completed filled in by the funera 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of cert 29c. License number SULEMAN UMAR. M.D. 5/20/11 Kes 0000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Suleman Square Drive, Baltimore, M.) 21237 9000 Franklin Umar 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Imend #22 Per FH G915 5/24/2011 JH. State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 201 rricore **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital 9. Birthplace Country) State or Foreign If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number . Age (In yrs. last birthday) **Funeral** Months 1 M 2 F 52 200-48-8613 /4/1958 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Lancaster York County PA 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 17602 2440 Douglas Drive USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 any injury or other traumatic event, the Medical Examiner must 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Dermatology Assoc. 12th Registered Nurse vrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Audra Steinman George D. Steinman ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2440 Douglas Drive Lancaster, PA 17602 Christian Moore- Husband Baltimore, 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of 20a. Method of Disposition Evans Crematory or other place)
Evans Cremat. Ser 5/25/2011 1 Burial 2 Cremation 3 Removal from State Leola, PA 4 Donation 5 Other (Specify) 22. Name and Address of Facility March Funeral Home, East 21. Signature of Fun ral Service Licensee well I'm 1101 E. north Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death))/Medical Due to (as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): attending physician Box 68760 by Physician/Medical as the l for use 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 mo ths?
1 ☐ Yes 2 0 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached P.O. 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes certificate 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onlone Be Other: Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation M 1 Yes 2 No death. 2 Accident s after death filled in by the Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide City or Town, State) 24 hours Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Funer completely fi Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) 30. Napre and address of person who 600 North Wolfe St, Baltimore, MD, 21287 Sa 101

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day Year) NAY 2 4 201

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Yea 1:29 AM Sharon Ann Murphy MA-2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ARUNDEL BALTIMORE WASHINGTON MEDICAL CENTER BURNIE ANNE (OLEN If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number Funeral Days Hours 1 M 2 X F Months Mary land Yrs. Director 217-52-7429 60 Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director 1 X Yes 2 No Baltimore City Brooklyn Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 200 Grove Park Road 21225 U.S.A. death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Black White etc. 1 X Never Married 2 Married "natural", or þ 1 Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the second to the Elementary/Seconday (0-12) College (1-4 or 5+) 12 Lab Technician Paint 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph William Murphy Rita Marie Oats 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita Schindler / Sister 8049 Veterans Highway, Lot 74, Millersville, MD 21108 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State MURPHY 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Anatomy Gifts Registry 05/23/2011 Hanover, Maryland 21. Signature of Funeral Service License Anatomy Gifts Registry 22, Name and Address of Facility 7522 Connelley Dr., Ste. P, Hanover, MD 21076 nelications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part 1. Enter the disease, occashock, or heart failure. List only Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Dav Year Pregnant at time of death signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has page performed this certificate 2 No 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral (Month, Day, Year) Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mono SATRIFERE MUDICITZ

State

Registrar

31. Date filed (Month, Day, Year)

MAY 24

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 18. Francis McHugh, Jr. 6:50 A M Simon Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery North Bethesda Brighton Gardens g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number . Sex 1 **X** M 2 □ F Age (In yrs. last birthday) **Funeral** Months February 28, 1938 Washington, D.C. 73 579-50-2824 Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State items 23a or 28a-f sho her must be notified at Director North Bethesda 1 Yes 2 X No Maryland Montgomery 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with United States 5550 Tuckerman Lane, Apt. 220 20852 "natural", or item edical Examiner m 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?
1 X Yes 2 No 1956-Black, White, etc. 1 Never Married 2 Married <u>\$</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Yes, Give Specify: White 3 X Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Builders Association Director 5+ Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental H f Item 27 is marked ot r other traumatic ever မ F. Grace Mae Winter McHugh, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 5209 Flanders Avenue, Kensington, Maryland 20895 Gregory L. McHugh /Son Department of Heal: Important: If item 2 any injury or other Date 19, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Montgomery Crematorium, Inc. 1 🗆 Burial 2 🗡 Cremation 3 🗆 Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 Signature of Fune of Service bicenses Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 10 M01305 23a. Part 1/Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Enysician/ Multiple Myeloma disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner End Stage Lung Disease Securationly list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Tes 2 X No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe 1 Yes 2 No Yes 2 X No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Assisted Other: 4 \square Nursing Home 5 \square Residence 6 \boxtimes Other (Specify)Living 1 ☐ Yes 2 🕱 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation s after death Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 - Homicide determined City or Town, State) .24 hou. Tuneral F Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 181 D27660 ted cause of death (Item 23a) (Type, Print) 30. Name and address of person who comple 11125 Rockville Pike Suite 110, North Bethesda, Maryland 20852

DHMH 17 Rev 7/2009

State

Registrar

W.D.

32. Registrar's Signature

Goswami,

Alpana 31. Date filed (Month, Day, Year)

MAY 24

11-03756		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	10000										
Marcus J. Nicker		State of Maryland / Department of Health and Mental Hygiene 2 1-For State Certificate of Death	10000										
Physicia Medical Examir	ın/	1. Decedent's Name (First, Middle,Last) 1. Decedent's Name (First, Middle,Last) 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year May 19, 2011	ime of Death 320 hrs										
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harbor Hospital 4d. County of Death Baltimore											
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 F 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 1 M 2 F 7. Age (In yrs. last birthday) 1 Months 1 Days 1 Min. 4 Ag (9 9 2	4.4.5										
any	F	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d.	. Inside City Limits										
	5	IND I NIA I BOLTIMORI	Yes 2 No										
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?											
with the		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Mrmed Forces? 14. Race - American I White, etc. White, etc.	ndian, Black,										
er death	Funeral	Armed Forces? 1 Yes Yes	L										
hours afte "natural" Examine	d b	15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Indus during most of working life. DO NOT use retired)	try										
11215-0036 Id be filed within 72 hours after death wifental Hygiene. sarked other than "natural", or items event, the Medical Examiner must be	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	haala										
5-0036 led within 7 Hygiene. other than		17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname)	WOO'S										
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene, "item 77 is marked other than "natural", or items 23a or 28a-f she r traumatic event, the Medical Examiner must be notified at once	To Be	19a. Informant's Name/Relationship (Type, Print) (Norther) 19b. Mailing Address (Street and Number or Rural Route Number, City or own, State, Zip	Code)										
e, MD 2 and 2 shoul Health and M item 27 is m		Ms. Denesha toyner 2602 USWego Are. Balto., MD 2	1215										
More, N Pages 1 and 3 rent of Health unt: If item 3		1 Burial 2 Cremation 3 Removal from State crematory or other place)	MD										
Baltimore permit. Pages 1 Department of F Important: If	ŀ	4 Donation 5 Other Specify: 21. Signar e of Funeral Service Licensee 22. Name and Address of Scility 23. Name and Address of Scility 24. Seph Liss Funeral Howe, P.A.	14()										
	_	(Valence Athan 1222) W. North Ave. Balto., MD	21316 proximate Interval										
Physician Medical		failure. Listonly one cause on each line. Immediate Cause (Final disease a. Multiple Gunshot Wounds	etween Onset and Death										
Examiner		or condition resulting in death) Due to (or as a consequence of):											
	Ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause											
ecuted and transit	Examine	C) (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.											
	dical	UNPENDED AMENDED											
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exting the hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	siciar	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	Year										
O. B. trhe de by the	Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the contribute to t											
of Vital Records, P.O. B ing Physician: The law requires that the defect that the date this certificate has been signed by the uneral director, page 2 should be detached.	ed by	1 Yes 2 ✓ No 3 Probably 24a. Was an 24b. Were autops	4 Unknown										
cords law requ has been	Completed	autopsy pnor to comp	letion of cause of										
1 of Vital Recing Physician: The I		25. Was case referred to medical 26.Place of Death (Check only one)	2 No										
Vita hysicia this cer	To Be	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other:											
on of ading P. th. : After e funera		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) May 19, 2011 28b. Time of Injury 1302 hrs 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred Subject shot											
Division of Vital Records, To the Hospital or Attending Physician: The law require within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should by	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural For Town, State)	loute Number, City										
Ospital hours a uneral ly filled		Homicide determined (Specify) Local Street 1000 Gretna Court, Brooklyn, MD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
o the H rithin 24 o the F	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ca and manner stated.											
A F * F 8	¥	29b. Signature and title of certifier 29c. License number 29d. Date signed (No. 2011) O.C.M.E. May 20, 2011											
		30. Name and address of person who completed cause of death (Item 23a)											
		Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223											
St Regist	tate trar												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10:40 A M hice 2011 D Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Hospital of Battimore Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🔀 F 215-30-993 and Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10b County 10a. State 10c. City, Town or Location 0d. Inside City Limits Director Baltimore 1 ✓es 2 □ No 10f. Zip Code 10g. Citizen of What Country? 21209 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Specify: Black 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) lerk Known Be 18. Mother's Name (First Middle, Maiden Surname 2 19b. Mailing Address (Street and Number or Rural Route Num G 70 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Sign of Funeral Service Licensee 12 alto 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Odays Immediate Cause (Final Acute Respiratory Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner days Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Renal Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death 1 Yes 2 9 Unknown 2 X No Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? 2 No Yes 2 No 1 Yes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 XNo မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 XNatural injury 5 Pending Accident Suicide Investigation 3 □ 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🛮 🗡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D70334 20,2011

2835 Smith Ave, Swite 203, Bathimore, MD21209

State Registrar DHMH 17 Rev 7/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Lijun Zhou N
31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Robert Nakashima May 2011 4:14 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** April 14 1 🛛 M 2 🗆 F Months Days Hours New York 483-46-1733 72 **Director** Usual Residence of Decedent 28a-f show 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Reisterstown MD. Baltimore 1 🗆 Yes 2 🎗 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12501 Dover Rd. 21136 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 Married Yes 2 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Asian/American Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Community Supervisor Recreation & Parks Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H Katsuhiro Victor Nakashima Sarah Kathleen Speagle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12501 Dover Rd. Reisterstown, MD. 21136 Susan M. Nakashima/ Wife Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1
Burial 2
Cremation 3
Removal from State Hilltop Service Co. injury or permit. Page Department of Important: If any injury or 5-23-11 Towson, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Ineral Service Licen 22. NRUCK ATOWS OF THE TUNE TO HOME, 1050 York Rd. Towson, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph, sician/ disease or condition resulting in death) DISTRIC ANCELL Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, ICPPATIC CANCER Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Janknown 022 DIABOTES MELLITUS 24b. Were autopsy findings available prior to completion of cause of autopsy death? ☐ Yes the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 🗆 📈 Other: 1 Yes 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of After t Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as statted. State 2 4 2011

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Barbara Oremlan	State of Manylana Population of the Manylana Man													
Physicia		Registrar Certificate of Death Reg. No.									3. Time of Death			
Medical Examin	er	BARBARA OREMLAND Month Day Year May 17, 2011									1830 hrs			
	ı	4a. Fecility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 6 Trotters Court Apt. T1 4c. County of Death Pikesville Baltimore C												nty
Funeral	4	5. Social Security Number	6. Sex	7.	Age (In yrs.	last birthd	ay)	If Under 1 Yea			of Birth (MN			hplace (State or
Director	1	218-52-6419	1 М	2 <u>X</u> F		63	Yrs.	Months Days	Hours	Min. 04/2	0/194		Foreigi Cou	intry) DC
any	F	Usual Residence of Decedent 10a. State 10b. County			10c. Cit	y. Town or	Location							10d. Inside City Limits
E	ا۔	MD BALTI	MORE			ESVIL					1 Yes 2 X			
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 10f. Zip Code								10g. Citizen of What Country?				
th the]		6 TROTTERS COURT 21208 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S							/ C'6 · V	USA or No- 14. Race - American Indian, Black,				
eath wi	Funeral	11. Marital Status 1 Never Married 2 No	12. Was Decedent Armed Forces?			J.S. 1		Decedent of His , specify Cuban			14. Race - White,		can Indian, Black,	
after de la	و بر	3 Widowed 4 X Di	orced If	Yes Yes, Give Year Dates:	ZA NO		1 🗌 Y	es 2 X No	specify:			Specify:	W	HITE
hours hours Exami		15. Decedent's Education (Spe Elementary/Secondary (0-12)	cify only I	nighest grade College (1-4		16a. De du	cedent's ring most	Usual Occupat of working life	ion (Give kind DO NOT use	of work done retired)	16b.	Kind of Busi	iness/Ir	ndustry
36 thin 72 te.	Completed	Elementary/Secondary (0-12)		5+	01 5+)	PH	YSIC	AL THER	APIST			MEDI	CAL	
21215-0036 vald be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle	, Last)							ame (First, Mid	dle, Maide	· ·		
2121 ald be fi Mental Marked cvent,	B P P	IRVING 19a, Informant's Name/Relation:	ship (Type	. Print)	G.	REENB		ddress (Stree	LILLIA		Number.		CHA State.	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiente. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumantic event, the Medical Examiner must be notified at once.	-	LAURA OREMLAN)5, B	ETHESD	Α,	MD 20814
s 1 and of Heal		20a. Method of Disposition 1 X Burial 2 Crematio	3 🗍	Removal from	Ctoto	crematory	or other	n (Name of cer place)		Date		. Location - C	-	Town, State
Baltimore, permit. Pages I an Department of Her Important: If the injury or other tr		4 Donation 5 Other S 21. Signature of Funeral Service	_		JU	DEAN		GARDEN		/20/201		LNEY,		
Ball permit Depart Impor		21. Signature of Funeral Service	Licensee				22. Nan 890	ne and Address O REIST	ERSTOW	OL LEVI N ROAD,	NSON PIK	& BRO ESVILL	S., E,	INC. MD 21208
Physician	1	23a. Part I. Enter the disease, o failure. List only one cause			sed the deat	h. Do not e	nter the	mode of dying,	such as cardia	ac or respirator	у аггеst, sh	nock, or hear	t	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Hy	pertensive			Disease	e						Death
		Sequentially list conditions,	b.	e to (or as a co	onsequence	of):								
	iner	if any, leading to immediate cause. Enter Underlying Cause		e to (or as a co	onsequence	of):								
d Sit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):												
		UNPENDED	d	MENDED										
	Med	IF FEMALE:		23c. If yes, ou	tcome of pre	gnancy					2:	3d. Date of d	elivery	
tox 68760, eath certificate be a attending physici for use as the buri	ian/	23b. Was decedent pregnant in t past 12 months?	=	etal death 3 Ectopic pregnancy ther (Specify)				Month Day Year						
Box 68760 e death certificate b the attending physic of for use as the bu	Physician/Medical	1 Yes 2 No 9 🗹 Un		9 Unknow	it at time of c	ieath 5	_ Other	(Specify)			-			
that the coned by the detached	by P	Part II. Other significant condi Diabetes mellitus, ob		ntributing to d	eath but not	resulting in	the und	lerlying cause g	iven in Part I.	_ I _			_	he cause of death?
Cords, P.O law requires that: has been signed b 2 should be detae		Diabetes meintus, or	-								24a. Was an 24b. Were autopsy			opsy findings available
e law re e has b	Completed			_						_ ,	erformed? es 2	de	ath?	ompletion of cause of
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rest after death. al Director: After this certificate has been signed by the finneral director, page 2 should be detach.	မ် ရှိ	25. Was case referred to medical	ii [26.Place	of Death (Che		es Z	1	Ye	2 110
Vita	인	examiner? 1 ✓ Yes 2 No	Hos		atient 2	_ ER/Outp				rsing Home		lence 6		Scene
in of Vi iding Physi h. : After this e funeral dir	ü	27. Manner of Death 1 Natural 5 Pen	dina	28a, Date of (Month, D	Injury ay,Year)	28b. Tin	ne of Inju		nyatWork? ∕es 2 ∏ No	28d. Desc	ribe how in	ijury occurred	3	
risior r Attend ter death irector: n by the	ficat	2 Accident Inve	stigation	28e. Place o	of Injury - At	home, farm	, street,	factory, office b	uilding, etc.			and Number	or Rur	al Route Number, City
DIVI	Certification:	4 Homicide	rmined	(Specify)						or To	vn, State)			
8 - 2 >	Medical (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)												
To witi	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Mon								th, Day, Year)				
		alis	1	N	Y	?		O.C.I	M.E.		Ma	y 18, 201	1	
151	Ī	30. Name and address of person Zabiullah Ali, M.D.					W Ral	timore Stre	et. Baltimo	re. MD 212	23			
Sta	te	31. Date filed (Month, Day, Year)			strar's Signa		50							
Registr	ar	MAY 2 4 2011	Lene		1. 160	aked				<u>,</u>				
DHMH 17 Rev 1/200 OCMF 2006	01		,	- /	17	ORIG	INAL					OCME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year Earnest Emmanuel Pack Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 701 N. Arlington Ave Apt.310 If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day Year)
Jan 2 9. Birthplace (State or Foreign Country) Mary Land 7. Age (In vrs. last birthday **Funeral** 5. Social Security Number 213-14-5274 Months Days Hours 1 5M 2 1 F 94 7 Jan. Director 191 Usual Residence of Decedent 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director be notified 28a-f N/A Baltimore Maryland Yes 2 No 10e. Street and Number 10f. Zip Code 21217 10g. Citizen of What Country? Arlington Avenuept.310 Funeral 23a 701 N. USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, e à 1 Never Married 2 Married Specify Black ☐ Yes 2 🔀 No Yes, Give Maryland 21215-0036 1 Yes 2XXNo Specify. XXWidowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the BGE Laborer 5th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Martha Wallace of Health and Mental H f item 27 is marked ot r other traumatic even James Levi Pack should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2009 Brunt Street Baltimore, Mary Land 21217 Department of Health an Important: If item 27 is any injury or other trau Ethel Malone /Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5/20711 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Brooklyn, Maryland Cedar Hill Cemetery 21. Signature of meral Service Licens 22. Name and Address of Facilit Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, MD Enter the wease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart finure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acult my o cars 1 m disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit HYPER CHOURS POROL that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical MYPER TRAVEIDED Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown been signed by the should be detached 1 Yes 2 L 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔁 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy • Hospital or Attending Physician: The 24 hours after death.
• Funeral Director: After this certificate P 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Persidence 6 Other (Specify) ျှ 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work?
1 Yes 2 No Accident Investigation completed filled in by the Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) and title of ce 29d. Date signed (Month, Day, Year) 133040 2 dress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and a Brown REVD · WINGTON をままるると BATIMOPIE MA X1230 700 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

MAY 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2.0 Day 2011 12:00 A M Elizabeth Ann Phelan May Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** B<u>altimore</u> Stella <u>Maris</u> <u>Lutherville</u> Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Months Days Hours (Month, Day, Year) July 6,1923 Maryland Director 220-14-180<u>5</u> Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 🗆 Yes 2 😿 No Timonium Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21093 United States 2300 Dulaney Valley Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Social Security College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Administration UNK. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Patrick Carey Phelan Marv Joseph Peach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Klinga<u>man/Guardian</u> 5019 S. Klee Mill Rd., Sykesville, Maryland 21784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, Metro Crematory Inc. 05/20/2011 Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland Alyson K Taylor 299 Frederick Rd., Baltimore, Maryland 21228 Part 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a. SEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No eral **urector**: After this certificate has been signed by the atte filled in by the funeral director, page 2 should be detached for a Year 5 Other (specify) Month Day Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 6 Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 1 Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. lnjury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred injury 1 X Natural 5 Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and the 29c. License number 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. JACKIE JONES, CRNP TIMONIUM, MD 21093

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

12:00

ELIZABETH PHELAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month May Physician/ 21 20Ï Î 9:25 Рм Lucile J. Payne Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 10450 Lottsford Road #250 Prince George's Bowie 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) **Funeral** Mar I, 1919 Months Days 1 □ M 2 👽 F Hours 92 Yrs 507-12-2682 Nebraska **Director** Usual Residence of Decedent or 28a-f show notified at death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🏋 No Maryland Prince George's Bowie 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 20721 10450 Lottsford Road #250 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. e filed within 72 hours after dintal Hygiene.
ed other than "natural", or it event, the Medical Examine 1 Yes 2 X No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 ▼ Widowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hospital Food Dietitian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic ever ျ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Jack Arthur H. Dora Laucomer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sara U. Ensor / Niece Sweetbriar Lane, Chapel Hill, NC 27514 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. | 05/23/2011 Baltimore, Maryland Signature of Funeral Service Licensee Alyson K Taylor 22-Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final and Death evialne Ph_sician/ moul disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examir 150L To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran o (or as a consequence of resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the ate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? p Diverticulosis 2 No 3 Probably 4 Unknown 1 Yes Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? certificate 2 🗌 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 🗌 Yes 5 Pending 2 🗌 No Accident Investigation Could not be Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, May 23, 2 re and title of certifi D0042049 Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 0235 AM 2011 Parker Mai B. Dorothy /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hosp, tal Balhmore Backmare 0-1 Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 □ F Months 214-24-5169 MD Director 06 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a State 10b. County ed other than "natural", or items 23a or 28a-f show event, the "Modical Examiner must be notified at 1 Yes 2 No Director Baltimore NA MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with U.S.A. 21207 Funeral 4001 Springdale Ave 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2√□No Specify: Black þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ...u wental Hygiene. 127 is marked other than "r. r traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Medi Care Supervisor 12th grade 2yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Marjorie I. Smith Alonzo Dutton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 3 Department of Health Important: If Item 27 any Injury or other tr. once. 4006 Springdale Ave, Baltimsore, Md 21207 Valerie Hall-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/23/2011 Baltimore, Md On-Site 21. Signa u e di Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, md 21215 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediat Cause (Final disease or condition resulting in death) Complications Associated Physician /Medical Due to (*r as a consequence of): Complications Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician a Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Day 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Tes 2 1 No 3 Probably 4 Unknown cate has been signated by page 2 should b Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 ☐Yes 2 ☐ No 1 □Yes 2 ☑No director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ves 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Matural after death.

I Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in I 24 hours a Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier within 24 hor To the Fune completely fi (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

Known As:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print), Alden (1. Peoples, MD Sinai Hospital) Peoples, MO 31. Date filed (Month, Day, Year) State MAY 24 2011 Registrar

> Deelenlitheoph

32. Registrar's Signature D. park

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ PHILLIPS Day MARGARET 05 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Randallstown Chapel Hill Nursing Center . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 M 2 X Days Hours Min (Month, Day, Year) **Director** 214-30-7310 97 20 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21201 U.S.A 1100 Pennsylvaņia Ave 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 Gres 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: Black Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private 8th grade Domestic nă Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ <u>Charles R. Phillips</u> Courtney Tate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reba Fitchett Brothers 190 West Northern PKWY Apt 222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/21/2011 <u> Memorial</u> Arbutus, 22. Name and Address of Facility
March F/H West
4300 Wabash Ave. Signature of Juneral Service Licensec Baltimore. Md 23a. Part 1 cinter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Im har late Cause (Final Onset and Death Physician/ ENO STAGE OEMENTIA Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of). Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 2 🕒 1 Tyes Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA eral Director: After thi filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) K. S. RAO. M.D 43462 MA 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 . S . R A . T . # 501 310 0/0 Courtra Rendallstown 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

ORIGINAL

DHMH 17 Rev 7/2009

Registrar

Wayne Guy Paige

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

INK UNK	State 1- For State Registrar	e of Maryland	/ Department o Certificate o		Mentai Hy	_	Reg. No.		
Physician/	Decedent's Name (First, Middle,La	ast)			1	2. Date of Dea		3. Time of Death	
Andical Examiner	Wavne	Guv		Paige		May 11, 2	2011	1645 nrs	
	4a. Fácility Name (if not institution, g 401 Light Street	ive street and flumber)		4b. City, Town, or L Baltimore	ocation of Death		4c. County of	f Death	
Funeral	Social Security Number 6.	Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8. Date of Bi	irth(MM/DD/YYYY)	Birthplace (State or Foreign	
Director		№ 2 F	25 Yrs		riodis i Willi.	01 0	7 86	Country)	
Ŷ	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Local	ion				10d. Inside City Limits	
.	MD Baltim	ore		esville				1 Yes 2 No	
the Maryland a or 28a-f show tified at once.	10e. Street and Number			10f. Zip Code		1	at Country?		
the M tiffed Dir	16 Sudbrook La	ne	08		Α.				
or items 23a must be noti	11. Marital Status	12. Was Decedent		as Decedent of Hispa es, specify Cuban, I	anic Origin? (Spe			- American Indian, Black,	
er dear	Never Married 2 Married Widowed 4 Divorce	u	No _	Yes 2 No		,			
hours after "natural", Examiner	15. Decedent's Education (Specify	or Dates:	-	nt's Usual Occupatio		ork done	Specify: 16b. Kind of Bus	Black iness/Industry	
5 72 ho 12 ho	Elementary/Secondary (0-12)	5+) during m	ost of working life. [OO NOT use retire	ed)				
5-0036 ed within 72 hour fygiene. other than "natu the Medical Exar Completed	10th grade	na	Une	mployed				loyed	
21215-0036 Mental Hygiene. Mental Hygiene. cerent, the Medical Examiner must be notified at once or Completed by Funeral Director	17. Father's Name (First, Middle, Las						Maiden Surname)		
212 ould be ould be d Ment be mark	Ronald Paige 19a. Informant's Name/Relationship	(Type, Print)	19b. Mailin	Address (Street	Joan Pa and Number or Ru	ige iral Route Nu	mber, City or Town	, State, Zip Code)	
p, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. trem 27 is marked other than "natural", or items 23a or 23a-fahe trammatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Joan Paige-Mot	her	16 8	udbrook	Lane,	Pikesv Pieke	ville ville	Md 21208	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withi Department of Health and Mental Hygiene. Important: If iten 27 is marked other ti injury or other traumetic event, the Med	20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from Sta	20b. Place of Dispos crematory or of		etery,	Date	20c. Location - (City or Town, State	
Baltimore, permit. Pages I ar Department of Hec Important: If ite injury or other tr	4 Donation 5 Other Specif		King Mem	orial Pa	ark 5/2	3/201	Woodl	awn, Md	
Ball permit Depart Impor injury	21. Signature of Funeral Service Lice	ensee	Ma	lame and Address o	West				
Physician	23a. Fart I. Enter the disease, or com-		the death. Do not enter t	OO Waba; he mode of dying, su	sh Ave, uch as cardiac or n	Balt respiratory an	imore, rest, shock, or hear	Md 21215 t Approximate Interval	
Micdical	Immediate Cause (Final disease	each line. Drowning						Between Onset and Death	
£xaminer	or condition resulting in death)	Due to (or as a conse	equence of):						
5	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	equence of):						
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Ox 6876 eath certificate attending phy for use as the I	past 12 months?	· L	time of death	taldeath 3 ∟ her (Specify)	Ectopic pregnand	су	Month	Day Year	
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Division of Vital Records, tal or Attending Physician: The law requires its after death. Tal Director: After this certificate has been signed in by the funeral director, page 2 should be artification: To Be Completed	-					24a. Was		ere autopsy findings available	
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tal Recions: The certificate ector, page	25. Was case referred to medical			26.Place of	f Death (Check on		2 10 1	7 100 2 110	
Physici r this c	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie					Residence 6		
n of oding 1. After funer funer ion:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day,Ye	ear)	4□ Va		8d. Describe Jnknowr	how injury occurre	d	
isio reteat rector by the	2 Accident Investiga	28a Place of Ini	-11 fd 4:4.	o pm				or Rural Route Number, City	
Division o spital or Attending tours after death. neral Director: After filled in by the fune Certification:	4 Homicide determine		ltimore Inne	er Harbor	В	orTown, s altimo	State#01 Li; re,MD.	ght Street	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the ledical Certification			knowledge, death occur						
2 Marie 2	one) 2 ✓ Medical Examine 29b. Signature and title of certifier	and manner stated.	nination and/or investigat	29c. License r		irie time, date		e to the cause(s) I (Month, Day, Year)	
	auet			O.C.M.			May 12, 201		
-	30. Name and address of person who	completed cause of de	eath (Item 23a)						
	Ana Rubio MD. Assista	ant Medical Exam	iner 900 W. Balti	more Street, Ba	altimore, MD	21223			
State Registrar	31. Date filed (Month, Day Year)	32. eg mag	's Signature						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2011 Physician/ May 19, 7:20 A M Eleanor E. Padgett Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 10019 Vanderbilt Circle #8 Rockville Montgomery If Under 1 Year | If Under 24 Hrs. . Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F Hours Months 108 218-52-6004 ĭ902 **Director** May Pennsylvania Usual Residence of Decedent 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 X No Maryland Montgomery Rockville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ems 23a or Funeral 10019 Vanderbilt Circle #8 20850 United States ural", or items 2 I Examiner mus · death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Examinury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Hugh Toner Eleanor Maloney 19a. Informant's Name/Relationship (Type, Print) Grandson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23603 Founders Place , Damascus, MD Richard P. Churchville, Jr./ 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or otl once. May 21, cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium Bethesda, Maryland 2011 Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. 21. Signature of Funeral Service Licenses - a. M01173 unthan Tuhn shull 7557 Wisconsin Avenue, Bethesda, Maryland 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Myocardial Infarction hours disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Dehydration days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) and -trar Due to (or as a consequence of): the burial attending physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🛣 No Day Pregnant at time of death 5 Other (specify) Month Year signed by the aid be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Osteoarthritis 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed? this certificate 1 ☐ Yes 2X No 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\) Other (Specify) 1 Yes 2 X No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c, Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After 1 X Natural 5 \square Pending injury Accident Investigation the 24 hours after deal Funeral Director; Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined Medical 🛮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) May 19, 2011 D31391 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suhair H. Abulfarag, M.D. 604 S. Frederick Avenue #413, Gaithersburg, MD

DHMH 17 Rev 7/2009

State

Registrar

Date filed (Month, Day, Year,

MAY 24 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death May Month Physician/ 21 2011 6:15 P M Sheila Mary Power Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🗶 F Months Davs Hours Min. July 1, 1961 Ireland 577-15-0922 49 Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County ä 10a. State 10c. City, Town or Location Director notified 1 X Yes 2 No Maryland Montgomery Chevy Chase 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or must be n ò Funeral 20815 Ireland 7610 Lynn Drive within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces?

1 Yes 2 No 5 þ 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 al Hygiene. I other than "natural", o event, the Medical Exan 1 ☐ Yes 2 K No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Real Estate Realtor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, and Mental Fis marked o ည Theresa Power Patrick Power permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7610 Lynn Drive, Chevy Chase, Maryland 20815 Lawrence Chartienitz / Husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of May Date 6 Montgomery Crematorium, Inc. 1 Burial 2 X Cremation 3 Removal from State 2011 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral envice Licensee
MigsfetteBarm w Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1, inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 1 Year Immediate Cause (Final Physician/ Colon Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin anding physician and use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy To the Hospital or Attending Physician: The law requires that the death c within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atten completed filled in by the funeral director, page 2 should be detached for u in the past 12 months?

1 Yes 2 X No Month Year 5 Other (specify) 5/31 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 🗶 No ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🖂 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D51616 May 21, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nelson Kalil, MD 5454 Wisconsin Avenue #1300, Chevy Chase, Maryland 20815 31. Date filed (Month, Day, Year) 32. Registrar's Signature State park MAY 24 Registrar 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No 2. Date of Death MAY 17 2011 DAVID MICHAEL QUIGLEY 4b. City. Town, or Location of Death 4c. County of Death MONTGOMERY BETHESDA 8. Date of Birth (Month, Day, Year) may 23,1941 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 1 X M 2 🗆 F Months Days Hours 69 10b. County 10c, City, Town or Location

For State Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 3:16 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner NATIONAL NAVAL MEDICAL CENTER Social Security Number 9. Birthplace (State or Foreign **Funeral** Country) Maine Director 004-40-9510 Usual Residence of Decedent 28a-f shov should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho 10a. State 10d. Inside City Limits notified at Director 1 Yes 2 No VA Prince William Woodbridge 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a Funeral 22192 USA 12841 Valleywood Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ⚠ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineering Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be file tment of Health and Mental H tant: If item 27 is marked of ပ္ Pearl Stuart Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12841 Valleywood Drive, Woodbridge, VA 22192 Marianne Quigley (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) May 21,2011 Dale City, VA Potomac Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Mountcastle Turch Funeral Home 4143 Dale Blvd. Dale City, VA 22193 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) CORONARY ARTERY DISEASE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' 1 ☐ Yes 2 🔀 No X Yes 2 No Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 🗆 Yes 2 🔀 No 1 A Inpatient 2 ER/Outpatient 3 DOA Other: ၉ 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred To the Hospital or Attending P within 24 hours after death.
To the Funeral Director: After it (Month, Day, Year) X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signaty 29c. License number 05-19-2011 H57227 and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER CRAIG WOMELDORPH BETHESDA MD 20889-5600 CDR MC USN 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 658 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 8:25 PM MAY Quillen Elizabeth Μ. 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore St. Joseph Medical Center Towson 8. Date of Birth May 05, 1910 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 🔽 F 213-60-2334 Mary land Yrs Director 101 Usual Residence of Decedent or 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director Lutherville 1 ☐ Yes 2 X No MD. Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be by Funeral 21093 USA 8511 Valleyfield Road Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. traumatic event, the Medical Examiner Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Mary Jane Davis John Morgan Mattingly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8511 Valleyfield Rd. Lutherville, MD. 21093 Elizabeth Ensor/ Daughter injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-24-11 Towson, MD. Hilltop Service Co. 22. Name and Address of Facility Ruck Towson Funeral Home, 21. Signature Funeral Prvice Licen York Rd. Towson. MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ONGESTIVE disease or condition Medical resulting in death) Due to (or is consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death ed by the a detached f 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform Yes 2 No 1 Yes Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 Other: မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Date of injury (Month, Day, Year) Manner of Death 28b. Time of ë 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Certifical 1 Yes 2 No after death Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge/ ceath occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one 29b. Signatur 29d. Date signed (Month, Day, Ya 52096

Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed &

UTZ

OSLER

DRIVE

21204

ause of death (Item 23a) (Type, Print)

-SCHNEIDERM

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death May 19, 2011 Physician/ 11:00 PM Erika Lynen Rinaudo Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore 1104 Concordia Drive Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days 6/30/1930 1 M 2 X F Santo Domingo 261-74-5913 80 Director Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits death with the Maryland 10a. State 10c. City, Town or Location must be notified at Director Baltimore Maryland Timonium 1 Yes 2 XNo 10f. Zip Code 10e. Street and Number 10a. Citizen of What Country? Funeral items 23a 2525 Pot Spring Road # S 124 U.S.A. 21093 13. Was Decedent of Hispanic Origin? (Specify Yes or No Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status "natural", or ite If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 X No Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: White If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Nay injury or other traumatic event. Banking Banker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ٩ Consuelo Messina Werner Lynen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lindsey Hughes / Daughter 1104 Concordia Drive Towson, Maryland 21286 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State Hilltop Service Corp. 5/20/2011 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 1050 York Road Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and the burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month 1 Yes 2 No ò Month Pregnant at time of death 5 Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Sp 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 잍 this 28a. Date of injury funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. (Month, Day, 1 Natural injury 5 \square Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Comparison of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and the 29d. Date signed (Month, Day, Year) 220-201

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State Registrar me and address of p

. Date filed (Month, Day, Year,

son who completed cause of death (Item

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Helen C. Riordan 2:45 AM May 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Baltimore City Hospital of Baltimore . Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Hours 83 December 20, 1927 Washington, D.C. Director 577-36-7605 Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified a 28a-f Maryland Carroll Taneytown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code b 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be Funeral 21787 212 Morning Frost Street United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rioardan 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 X No β Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White If Yes Give 1 Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12 College (1-4 or 5+) d Mental Hygiene. marked other tha Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Clarice Way John Gilmore and lisi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Ann M. R. Brockhaus/Daughter 4518 Saul Road, Kensington, Maryland 20895 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May Data. cemetery, crematory or other place)
Gate of Heaven 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2011 Silver Spring, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Betherda-Chevy Chase Inc. 7557 Wisconsin Avenue Betherda, Maryland 20814 Signature of Funeral Service Licensee M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Obstructive hydrocepholus with brainsteur herviation
Due to (or as a consequence of): Ph_sician/ disease or condition resulting in death) Medical **Examiner** 38 hours lutra cerebra Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). use as the burial-transi that initiated events Due to (or as a consequence of): physician Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Physician/ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? for 5 Other (specify) Month Day Year Pregnant at time of death 4 ☐ Pregnant a 9 ☐ Unknown signed by the a 1 Yes 2 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by hyperlipidemia Hypertension 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a, Was an disease certificate has To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital 2 No ပ္ 1 Mnpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural iniury 5 Pending death. 2 Accident
3 Suicide Investigation within 24 hours after deatl To the Funeral Director: completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) RES-000 May 19, 2011 101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital of Baltimore Nate filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10:28 p_M Monthly 9, Day 2011 Lester Salmond, Sr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death
Baltimore Gilchrist Hospice Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** 1 XM 2 - F Days Hours 06/11/1956 214-64-1037 54 **Director** Usual Residence of Decedent 28a-f show should be filed within 72 hours after death with the Maryland at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f sl edical Examiner must be notified MD n/a Baltimore 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1319 North Montford Avenue 21213 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: SpecifyBlack 3 Widowed 4 Divorced Completed Year or Dates. Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life, DO NOT use retired)
Laborer 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 1Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Mississippi Grain Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Boykin Salmond Jr. Elsie L. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Salmond-Wife 1319 N. Montford Ave Baltimore, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) King Memorial Park Randallstown, MD 5.20.2011 Signature of Funeral Service Licensee Chatman—Harris Funeral Home 5240 Reisterstown Rd Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). the attending physician and hed for use as the burial-translt or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) signed by the atter in the past 12 months? Day Pregnant at time of death Month Year 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by funeral director, page 2 should 1 🗌 Yes 2 No 3 Probably White 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has k
completed filled in by the funeral director, page 2 s autopsy perform 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 0 Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Other (Specify 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) injury 5 Pending work? ☐ Accident Investigation 3 Suicide 4 Homicide 6 ☐ Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one the 2 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Mo

Charles ST POUSON MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Smil Physician/ 3 : 25 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1800 Green Spring Valley Road Stevenson Baltimore Social Security Numbe If Under 24 Hrs Hours Min. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 215-34-9938 1 🗆 M 2 💢 F Months Days (Month, Day, Ye Baltimore, MD 96 **Director** 1914 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matter at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Stevenson 1 Yes 2 X No MD 10e. Street and Number 10f. Zip Code 109. Citizen of What Country? by Funeral 1800 Green Spring Valley Road 21153 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 V Yes 2 No WWIII If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Specify: Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Education Elementary/Seconday (0-12) College (1-4 or 5+) Teacher 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Kenicott Culver Frances Strader 19a. Informant's Name/Relationship (Type, Print Dauchter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Smith Green 1800 Green Spring Valley Rd. Stevenson, MD 21153 Date **23,** 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Evans Funeral Chapel - Bel Air 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 2011 Forest Hill, Maryland . Signature of Funeral Service lice see 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services
16924 York Road, Monkton, MD 2111 1 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Orget and Deat nediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a or nsequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Pregnant at time of death 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform certificate 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 - No Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury Natural 5 Pending death. 1 ☐ Yes 2 ☐ No Accident Investigation after death Director, Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours aft

To the Funeral Di

completed filled in Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the ၉ Sh

State Registrar

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Falls Nd. Side 255. Lutherville, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 1:00 PM Richard J. Svehla May 2Ĭ 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Riverview Nursing Home Essex 8. Date of Birth (Month, Day, Year) Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours 1 X M 2 □ F 217 - 01 - 565391 **Director** Mary bnd Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State Director MD Baltimore Baltimore 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Ь "natural", or items 23a or edical Examiner must be Funeral 21234 9721 United States Britinay Lane 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give Specify: White and 2 should be filed within 72 hours at the Health and Mental Hygiene. If item 27 is marked other than "natural". Completed 3 Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Bugel Linen Elementary/Seconday (0-12) College (1-4 or 5+) Route Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNK ည Joseph Svehla 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9721 Britinay Lane, Baltimore, MD 21234 Gary Svehla/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place of Faith 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite May 25, 1 X Burial 2 Cremation 3 Removal from State 5 Rosedale, Maryland injuny 4 Donation 5 Other (Specify) <u> 2011</u> Cemetery 22. Name and Address of Facility Evans Runeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 Signature of Funeral Service Licensee art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Onset and Death In mediate Cause (Final Cardiovas ullar bisease Pnysician/ ATIL disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Due to for as a consequence of: To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 X No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 🔀 No 1 Tes 은 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work's 1 X Natural 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Battimore, MP 21271 31. Date filed (Month, Day, Year) State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Mame (First, Middle, Last) Day Month :30 P.M **Physician** 2 2011 /Medical 4c. County of Death 4h City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, **Examiner** Baltimore Parkville Perring Parkway Genesis | Hunder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State (Month, Day, Year) | 9. Birthplace (State (Month, Day, Year) | 1925 | Mary Land 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🙀 F 85 217-38-4047 Director Usual Residence of Decedent 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 23a or 28a-f show Department of Heath and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at Director Parkville 1 ☐ Yes 2√☐ No Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 USA 1801 Wentworth Avenue Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State Of Maryland Social Worker 5+ 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Marie Juengst August Baer ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21206 4106 Marx Avenue-Baltimore, Maryland Raymond Scanland III -son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Moreland Memorial May 25,2011 20c. Location - City or Town, State Pages 1 g 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Parkville, Maryland 4 Donation 5 DOther (Specify) 22 Name and Address of Facility 21. Signature of Funeral Service Licensee Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Progressive decline **Physician** disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner ny Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Tarkinsons Due to (or as a consequence of) Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.0. 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has 3€ No 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 ☐ Pending investigation 1 □Yes 2 □No ours after death. leral Director: A filled in by the fu 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

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DHMH 17 Rev 1/2001

State Registrar

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Divic

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marcia Soulsman

31. Date filed (Month, Day, Year)

05

7625

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20° 2011 Andrew Thomas Slaich \mathbf{p}^{M} 4:15May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford 510 W. <u>Jarrettsville Road</u> Forest Hil If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland Days Min 1 🕅 M 2 □ F Months Hours March 15,1923 88 Director 213-20-9259 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 X No Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 510 W. Jarrettsville Road 21050 United States within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1v Yes 2 No If Yes, Give 1 Q Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. r Yes, Give Year or Dates. 1942–46 White Specify: "natural" Completed 3 Widowed 4 Divorced event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) North Arundel Savings Elementary/Seconday (0-12) College (1-4 or 5+) Bank Bank President Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked မ Andrew Thomas Slaich Birmingham Emma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Dorothy I. Slaich / Wife 510 W. Jarrettsville Rd. Forest Hill, MD 21050 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 05/23/2011 Baltimore, Maryland Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 299 Frederick Rd., Baltimore, Maryland 21228 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence or): if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events and -tran Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death 2 No. g 🗌 Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician; The law requires Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 2 No 1 Yes Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tyes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' in 24 hours after death.

In Funeral Director: At bleted filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 **To the I** Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 30. Name and address of person who completed cause of eath (Item 23a) (Type, Print) RTH AVE 31. Date filed (Month, Day, Year) State 24

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 2. 2<u>011</u> Physician/ Antoinette Jean Schield 9:21 Ам May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death
Baltimore 4b. City, Town, or Location of Death Towson Greater Baltimore Medical Center 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Dec. 2, 1942 1 M 2 X Hours Director 219 40 0149 68 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Direct Maryland Baltimore Essex 1 Yes 2 X No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 23a Funeral 1441 Sussex Rd. USA 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black White etc. þ 1 Never Married 2 Married "natural", or hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th Cook Baltimore County Schools injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillian Piwinski William Kleinsmith permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic s 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1441 Sussex Rd. Baltimore, Maryland 21221 Joseph Edward Schield (Husband) Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State ry or other place) 1 XBurial 2 Cremation 3 Removal from State Holly Hill Mem. Gardens 5/25/2011 |Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service License ^{22. Name and Address of Facility}
Bruzdziński Funeral Home P.A. 1407 old Eastern Avenue Essex, W. Maryland 21221 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last burial-Physician/Medical Box 68760 attending physical for use as the b IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death ed by the g Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe now injury occurred Hospital or Attending 1 .Natural 2 X Accident work? 5 Pending 46 lay 21 2011 un known Investigation within 24 hours after deatl To the Funeral Director:. completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, Rd City or Town, State) (1114) 5458 EX. RSSEX, Md 4 Homicide determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check only one 29c. License number 29d. Date signed (Month, Day, Year) eted cause of death (Item 23t) (Type, Print) 0 State

Registrar

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ore	e 1 and t of Heal If item or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		20b. Place of Dis	position (Name of rematory or other pla	ce)	Date	20c. Location	- City or To	wn, State		
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\ \			30 Name and address of person who	completed cause of	death (Item 23a) (Type	Print) Char	1P) An	PH TOL	Jan	mD?	21204		
	Sta Registr:		31. Date filed (Month) Day, Year)	32. Regist	ar's Signature								

11-03684 Joy Cecilia Strong Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Judy Ann Strobell 2011 2:50 May Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Montgomery 4b. City, Town, or Lo Rockville or Location of Death **Examiner** Casey House 7. Age (In yrs. last birthday) 58 Yrs. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 3/2/1953 Days Hours 212-64-9432 1 □ M 2 😿 F **Director** Usual Residence of Decedent items 23a or 28a-f shov her must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director MDMontgomery Rockville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 4614 Coachway Drive 20852 USA death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, o. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ☐ Yes Yes, Give 2xxNc Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No Specify: "natural" 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools Para-Educator Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Eugene John Lindberg Agnes Ann (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Strobell, husband 4614 Coachway Drive Rockville, MD 20852 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department o Important: If any injury or 05/24/2011 4 Donation 5 Other (Specify) Science Care Aurora, CO . Signature of Tup 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Cerebrovascular accident disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Diabetes Mellitus Sequentially list conditions Due to lor as a consequence of cause. Enter Underlying Exam Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last the burial physician Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as attending I IE EEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 Day Pregnant at time of death Yes 2 X No ed by the a 9 Unknown 9 Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Division of Vital Records, Coronary Atherosclerosis 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform this certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific.
completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \(\superstack \text{Yes}\) 2 🔀 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1XXNatural work? 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide City or Town, State) Hospital Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the only one 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 29c. License number 5/17/2011 D37142 30. Name and address of berson of Coleman MD: n completed cause of death (Item 23a) (Type Print) 18101 Prince Philip Drive Olney, MD 20832 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day 22 2011 10:50 A_M STEINBACH STANLEY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death GILCHRIST HOSPICE TOWSON BALTIMORE Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 216-56-1156 1 X M 2 🗆 F Months Days Hours Min 0470271922 89 Director MD Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland Director Town or Location 10d. Inside City Limits BALTIMORE PÍKESVILLE MD 1 🗌 Yes 2 💢 No 10e, Street and Number ō 10f. Zip Code r must be r 10g. Citizen of What Country? Funeral 1 SLADE AVENUE #203 21208 USA items ? within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: WHITE "natural" 3 Widowed 4 Divorced Specify Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) PHYSICIAN MEDICAL Be 17. Father's Name (First, Middle, Last) of Health and Mental H f item 27 is marked ot r other traumatic ever 18. Mother's Name (First, Middle, Maiden Surname) 2 STEINBACH ROUM I.D. ROSE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh nt of Health a FLORINE STEINBACH/WIFE 1 SLADE AVENUE #203, PIKESVILLE, MD 21208 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State BAT TO HEBREW CEMETERY ò Department of Important: If any injury or once. 05/23/2011 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) Fufferal Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complica ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one ause on each line Interval Between Immediate Cause (Final Onset and Death Ph sician/ act al loss Ceren asserte Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to firm solute cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of, attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Month Day Year n signed by the a Id be detached f g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No ျ 1 Tes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending in 24 hours after deau...
the Funeral Director: Aft Accident 1 Tes 2 No Investigation Suicide 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated The certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 99 1301

Registrar

DHMH 17 Rev 7/2009

State

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ 2011 Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** 4b. City, Village MO 8. Date of Birth (Month, Day, Year If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗹 F Min. 0 Months Hours Director items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director Yes 2 No More 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or i 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 1 🗆 Yes 2 🗖 No 3 ₩idowed 4 □ Divorced lack Year or Dates Baltimore, Maryland 21215-0 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Aint) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21231 00 Ba 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State any injury 4 ☐ Donation 5 ☐ Other (Specify) Signal e If Funeral Service License acruss Elle Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or iinjury Due to for as a consultience of Exami the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month the 9 Unknown detached g Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pe Division of Vital Records, 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? certificate 1 ☐ Yes 2 ☐ No or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 - Nursing Home 5 - Residence 6 - Other (Specify) 2 HNO ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D57543 PHYSICIAN 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 1940W, BALTIMOREST. BALTIMOREMP21223 PRETINDER SANDHU MP 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

11-03844 Robert V. Todd

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3 Time of Death Physician/ Month Day May 23, 2011 **Medical Examiner** 0001 hrs Robert Vernon Todd, Jr. Jr. 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore County Greater Baltimore Medical Center Towson 5 Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year I If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** oreian Months Davs Director 212-38-4512 Feb 24, 1940 Countraryland 1X M 2 F 71 Yrs Usual Residence of Decedent iny 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 No 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

nnt: If item 27 is marked other than "natural", nr items 23a or 28a-f sho Marvland Baltimore City Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2023 Druid Park Drive 21211 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 1X Yes 2 Specify: WHITE 4 X Divorced or Dates: 1957-61 3 Widowed 1 Yes 2X No specify: ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) the Medical Baltimore, MD 21215-0036 12th grade Computer OPerator Insurance 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Robert Todd, Sr. Be Dorothy Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 Scott Todd, SON 1 Athenry Court Apartment #304 Timonium MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State crematory or other place) nr nther 4 Donation 5 Other Specify Metro Crematory INC 05-24-2011 Baltimore, Maryland Signature of Funeral Service Licensee Patrik Fleming 22. Name and Address of Facility Cremation Society Of Maryland 299 Frederick Rd, Catonsville MD 21228 INC that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Driset and /Medical Death a Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease ixaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any leading to immediat Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician and be detached for use as the bunal - transit **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. Physician/Medical AMENDED 23a,pt.II,27,per me,g918 8-5-11 sm [tem las noted.per me,g918 8-5-11 sm ™ UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Dav past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Chronic obstructive pulmonary disease; Renal Insufficiency; Completed ficate has been s 24a Was an 24b. Were autopsy findings available Hypothyroidism; deep venous thrombosis prior to completion of cause of autopsy this certificate has performed' ✔ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other Nursing Home 5 Residence 6 Other 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) After 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred cation in 24 hours after deam.
the Funeral Director: Af 1 X Natural 5 Pending 1 Yes 2 No Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 6 Could not be 3 Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. one)

Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s). ca within 2 2 Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E May 23, 2011 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

DHMH 17 Rev 1/2001 **DCME 2006**

State

Registrar

QCME

2011

31. Date filed (Month, Day, Year)

MAY 24

Parks **ORIGINAL**

32. Registrar's Signature

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			19a. Informant's Name/Relationship (Type, Print) Gladys Thompson/ Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 42 Hillvale Road, Paltimore, Md 21229													
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2.06 pm James Arnold Tucker, Sr. 2011 /Medical County of Death give street and number Town, or Location of Death Examiner 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age **Funeral** Davs 1 🙀 M 2 🗆 F Months 52 216-74-6513 April 4, 1959 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c, City, Town or Location 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar is ust be retified at MD 1 ☐ Yes 2 V No Director Baltimore Windsor 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 7141 Rolling Bend Rd. Apt. A 21244 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐Yes 2√2 No Specify: Specify: Black 3 ☐ Widowed 4 ₺ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) US Air Force 12th 4 yrs. <u>Computer Specialist</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Percy A. Tucker Emma Hill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JoAnne Richardson-Sister 4103 Holbrook Rd. Randallstown, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) 5/26/2011 Baltimore, Md On-Site 21. lignatu e of Funeral Service Licens 22. Name and Address of Facility 4300 Wabash Ave. March Funeral Home West, Inc. Balto. 23a. Part 1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fature. List only one cause on each line. Approximate Interval Between Onset and Death Immedi e Cause (Fin-MYOCARDIAL INFARCTON **Physician** MINUTE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for easy consequence off. cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami burial-transi Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death Day 5 ☐ Other (specify) icate has been signed by , page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2 No 1 ☐ Yes Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? ie Hospital or Attending Pl 24 hours after death. ie Funeral Director: After t 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🔲 Homicide 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only one)

State Registrar

MARIUS 31. Date filed (Month, Day, Year) 24

30. Name and address of person who complete

29b. Signature and title of certifier



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Thomas, James

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ledical Exam	iner	Beverly Denise Frazier Thomas	Month May 6, 201	Day Year									
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of	Death	4c. County of Death									
		3700 Greenspring Avenue Apt. 318 Baltimore		N/A									
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215-0036 be filed within 72 hours after death with the Maryland mal Hygiene. riced other than "natural", or items 23a or 28a-f she eart, the Medical Examiner must be notified at once	Be C		18.Mother's Name (First, Middle, Maiden Surname) Ellen Gambril										
MD 21215-0036 at 2 should be filed within 7 at Mental Hygienc, n 27 is marked other than umatic event, the Medica	일	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number											
Baltimore, MD 21215-00 permit. Pages a land 2 should be filed with Department get leadle and Mental Hygien Important: If item 27 is marked other injury or other traumatic event, the M.		Donnett Johnson(niece) 2019 N. East Ave., Baltimore, MD											
Fe, s l an f Hea		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)											
Page Page nent o		4 Donation 5 Other Specify: on-site Crematory	05/20/11	Baltimore, MD									
Baltimore, permit. Pages I an Department of Hea Important: If iter	l) j	21. Signature of Funeral Service Licensee	wn Jr. Fi	neral Home PA altimore,MD 21217									
	5 S												
Physician dinal		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as care failure. List only one cause on each line.		Between Onset and									
xaminer	ïï	Immediate Cause (Final disease or condition resulting in death) a. Hypertensive atherosclerotic cardi	ovascular	disease Death									
		b											
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Jause											
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e exec	lical	☐ AMENDED 23a,27,per me,g915 5-25-11 s	m										
68760, certificate be nding physici	¥	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery											
687 certificant ading	ian	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic p	regnancy	Month Day Year									
A - 031	Physician/Med	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown											
O. E at the if by th		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	I. 23e. Did tob	acco use contribute to the cause of death?									
of Vital Records, P.O. Boying Physician: The law requires that the death After this certificate has been signed by the att funeral director, page 2 should be detached for	d by		1 Yes	2 No 3 Probably 4 Vunknown									
rds requi	lete		24a. Was ar autopsy										
eco he law te has	Completed		perform	ned? death?									
Division of Vital Records, as of Attending Physician: The law requires after dead to the factor. After this certificate has been sited in by the funeral director, page 2 should be		25. Was case referred to medical 26.Place of Death (Ci		10 100 2 100									
Vita	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 1 No	lursing Home 5 R	esidence 6 🗹 Other: Scene									
Of After uneral		27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe ho	w injury occurred									
teath.	aţio	1 Natural 5 Pending 2 Accident Investigation	0										
ivis lor A after of Direc	ţį	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Str or Town, Sta	reet and Number or Rural Route Number, City									
Division of Vital Rec To the Hospital or Attending Physician: The within 24 hours after death. To the Funcral Director. After this certificate completely filled in by the funeral director, page	Certification:	4 Homicide determined (Specify) 29a. Certifier 4 Cartisting Physician: To the best of my keep yields double segured at the time date and also		·									
the H the Fu	ca	check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur											
To the within To the comple	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (Month, Day, Year)									
		O.C.M.E.		May 17, 2011									
/		30. Name and address of person who completed cause of death (Item 23a)											
Ø		Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD	21223										
	ate	31. Date filed (Month, Pay Year) 32. legistrar's Signature											
Regis	trar	MAI 24 2011 Chrom p. Mar											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $2\overset{\text{Year}}{0}1$ Vovak Ronald 5:45 A M Daniel May Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Rockville Montgomery Casey House If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Social Security Number 6. Sex Age (In yrs. last birthday) Days Hours (Month, Day, Year) [av 15, 1972 Min. 1 **X** M 2 □ F 39 **Director** Ohio 277-82-8999 May Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location the Maryland Director or 28a-f sl e notified a Bethesda 1 Yes 2 No Montgomery permit. Page 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hygiene. Important: If item 27 is marked other than "man any injury or other traumation." 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 7506 Newmarket Dr. 20817 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2**XX**No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married 1 Yes : 1 ☐ Yes 2XXNo Specify: White Specify: 3 Widowed 4XXDivorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Writer Journalism Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Henry Vovak Hale Ronald Lee Ann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher L. Vovak / Brother 4290 Scarlet Oak Dr., Copley, OH 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 5/23/2011 Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD Ma0 382 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ ANGIOSARCOMA disease or condition) Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day ģ Month Year Pregnant at time of death Yes 2 No by the a g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? page 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 🗶 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1XXNatural 5 Pending work? 1 ☐ Yes 2 ☐ No after death. М Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical 1 🗴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37142 MAY 21, 2011

Registrar

DHMH 17 Rev 7/2009

State

6001 Muncaster Mill Rd., Rockville, MD

20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Geoffrey Coleman M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Ruth Τ., Varina 21 2011 May 11:17 a^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7466 E. Furnace Branch Rd. Apt. 415 Glen Burnie Anne Arundel Co. 9. Birthplace (State or Foreign Country)
New Jersey Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 04/28/1940 1 M 2 XF 145-32-8312 **Director** 71 Usual Residence of Decedent 10b. County 10a. State ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Co 1 Tes 2 No Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21060 United States 7466 E. Furnace Branch Rd. Apt. 415 death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc 9 þ 1 Never Married 2 X Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 ☐ No Specify "natural", Specify: Completed 3 Divorced 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be Department of Health and Mental Himportant If item 27 is marked oth any injury or other traumatic ammone. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Ralph Parker Ruth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21060 Mr. Donald Varina / Husband 7466 E. Furnace Branch Rd. Apt. 415 Glen Burnie, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State 5/23/2011 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Glen Burnie, MD 21. Signatur f Funeral Civic Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as a col sequence of) Examiner Sequentially list conditions, Examine Days to for as a nonsequence of cause. Enter Underlying Cause (Disease or linjury that initiated events burial-trar Due to (or as a consequence of) resulting in death) Last attending physiciar Physician/Medical certificate be Box 68760 as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ō Month 5 Other (specify) Pregnant at time of death detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician: The law requires 2 No 3 Probably 4 'Unknown Completed 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy perform certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 XYes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury death. 1 ☐ Yes 2 ☐ No Accident Suicide Investigation filled in by the within 24 hours after deat

To the Funeral Director:
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier , Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29d. Date signed (Month, Day, Year) D06054 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TONES 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** Kichard Wheeles 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 29, 1923 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F 87 228-14-0455 Bridgewater, VA Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State show MD Harford Joppa 1 ☐ Yes 2X No Director 28a-f s Examiner must be notified 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number ö 21085 413 Timber Lane United States "natural", or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 □ No
If Yes, Give Year or Dates: 4 3 - 45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or Ite 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Covernment Chief of Highways 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jacob R. Wheeler Sadie Howdyshell 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Wheeler- Wife 413 Timber Lane, Joppa, MD 21085 Department of Health a Important: If Item 27 Is any Injury or other trains 20b. Place of Disposition (Name of cometers crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 25, 1 Burial 2 Cremation 3 Removal from State May Forest Hill. 4 ☐ Donation 5 ☐ Other (Specify) Chapel -Bel Air 2011 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services 21. Signature of Funeral Service Licensee 3 Newport Drive, Forest Hill, MD 21050 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician asy stole Minuk disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner actic across Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): MRSA preumona, Closty dum DiFicile ixret The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 2 No P.O. 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, 1 Tyes 2 No 3 Probably 4 Unknown the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Tes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 \sum Nursing Home 1 ☐ Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 2 this Date of Injury (Month, Day Year) 27. Manner of Death Time of injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation Injury 1 Tes 2 □ No death, Director; Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide hours after To the Hospital or within 24 hours at To the Funeral Di TS Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only one) and manner stated.

State Registrar

29b. Signature and title of certifier

(has AUDIZEY 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

11595

29c. License number

RG- CU

29d. Date signed (Month. Day, Year)

22

Ucus

4940 Eastern Avenue, Baltimore, MD, 21224

20/1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not instilution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Seasons Hospice @ NW Hospital Ba Itimore Kandallstann Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 1 MM 2 □ F Month Day 7.0679 Yrs Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD Battimore Randallstown 1 Yes 2 No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? Funeral [23a 21133 1154 items ? Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, marked other than "natural", or iter matic event, the Medical Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Back 3 Divorced 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha U.S. Posta Dervice) Exteditor 2th grade Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Walle Katherine Jackson 27 is marked 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Waller 3808 Hook Road Randallstown MO21133 andri aleria item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it 5 1 Surial 2 Cremation 3 Removal from State cemetery, crematory or other place, injury or Owings Mills, MD 2011 4 Donation 5 Other (Specify) Garrison 21. Signature of Funeral Service Licenses any inj Valighn C. Greene Filmen sovices 22. Name and Address of Facility andallstown MD21133 d 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest adure. List only one cause on each time. Approximate Interval Between shock, or heart fa Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) neumo Medical ue to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) and that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year the a Unknown 9 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by completed filled in by the funeral director, page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 🔭 No Be 26. Place of Death (Check only one) Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Joseph Edgar Weitzel Month Year 2:52 AM 201 Medical May Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Rosedale HODDITEL If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland **Funeral** 7. Age (In yrs. last birthday) Month Day, 1 **XX**M 2 □ F Days 213-32-4923 Hours 1935 Director 75 June Usual Residence of Decedent or 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🖾 No Baltimore Middle River Maryland 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be 21220 Funeral USA 13010 Eastern Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married δ Maryland 21215-0036 1 ☐ Yes 2XX No Specify: 3 Divorced 4 Divorced Specify. White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event: the Ma Elementary/Seconday (0-12) College (1-4 or 5+) Unknown Fork Lift Operator Newspaper Recycling Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13010 Fastern Avenue, Middle River, MD 21220 Pamela Riley Daughter-in-law Baltimore, Weitzel 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Memorial 20c. Location - City or Town, State 1 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State 5/26/2011 Elkridge, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Burgee Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland Burgee Henss-Sei 3631 Falls Road, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Anemia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner GI bleed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur completed filled in by the funeral director, page 2 should be detached for use as the bur P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records. COPD, CAD 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? cardiomyopathy 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Suicide Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State, Medical 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 201 who completed cause of death (tem 23a) (Type, Print) ourtney B. McCluskey, M.D. 9000 Franklin Square Drive Baltimore MD 21237 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#26perpHYS, G915, 5/24/2011, WS State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Dav Year Month Workman Richard Wayne Medical 2011 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u> 3901 Liberty Heights</u> Ave 2nd Baltimore 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min **Director** 218-58-3600 NC Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Sant. If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD NA Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 3928 Grantley Road .S.A Was Deceud.
Armed Forces?

Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2th grade Tailor Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John Henry Workman Sarah Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Denika W. Russell-Daughter</u> 1136 North Fulton Ave. Baltimore, Md 21217 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any in]ury or ot 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) On-Site 5/17/2011 Baltimore, Md Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Av Ave, Baltimore, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph, sician/ a ATHEROS Cleronc disease or condition resulting in death) cordispersion duesse UNCOUR Medical Due to (or as a consequence of); Examiner Sequentially list conditions, if any, and ling to immediate Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence off: Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transi resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No 1 | Yes 2 | 9 | Unknown 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy performed Yes 2 2 No 1 Yes Be 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) examiner? Place of Hospital Other: 4 Nursing Home 3 Thesidence 6 K Other (Specify) Business 2 **N**0 မ 1 Inpatient 2 ER/Outpatient 3 DOA After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural iniury 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director, A Accider
Suicide Investigation 6 Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practioner: To the best of my knowledge of action or many at the time, date and place, and due to the cause(s) and manner stated (Check only or 29b. Signature and title of certifier 29c. License number 29d. Date s gned (Month, Day, Year) MO D0054056 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bell Mp 6821 aluje Reistustoun Rd 21215 MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2011 2 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1104AM Shirley A. Williams Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4c. County of Death 39 ware 08 DitaL osedale Daltimore Social Security Number 6. Sex 8. Date of Birth
(Month, Day, Year)
July 10,1945 If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2🗶 F Days Maryland Yrs. **Director** 219-44-8676 65 Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits rector Md. Balto. Parkville 1 Yes 2 No ā 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 4102 TaylorAvenue Apt. 208 21236 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 【X No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Máryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) n and Mental Hygier 7 is marked other t 12th ssistant Manager Banking Be permit. Page 1 and 2 should be filed. Department of Health and Mental Hw. Important: If item 27 is meany injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Salvatore LoPresti Rose Moscato 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Castino Nephew 615 Norman Road York, Pa. 17406 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gardens of Faith 5-25-2011 Balto. Md. 21. Signature of E 22. Name and Address of Facility Schimunek FuneralHome 9705 Belair Road Nottingham, Md. 21236 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate
Interval Between
Onset and Death
UnKYIOTON shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) arrhu Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any loading to immediate Examiner cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director; After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit Dertension that initiated events resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death Month Dav Year 4 ☐ Pregnant : 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 1 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No Other: Certificate: To 1 Tes 1 Inpatient 2 ER/Outpatient Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Tyes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certification 29d. Date signed (Month, Day, Year) 21,2011 62862 may 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

filed (Month, Day, Year)

24

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physicia		For Amend Item 1 State Registrar Decement's Name (First, Middle, Last)	State of Masylan, per dr., gyylan, Edward	66 POPPS Certi	tongrated Ficate of L	lealth and Death	Mental Hy 2. Date of De	Reg. No.	0 1 2011	3. Time of Dea	
/Medic Examin		4a. Facility Name (If not institution, give s The Johns Hopkins Ho	·	1	Baltimore				ounty of Death		
Later with the Maryland ms 23a or 28a-f show must be notified at		213-36-4716	7. Age (In yrs. 7)		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da	th ly, Ye <i>ar)</i> 1/1940	Count		reign
	ctor	Usual Residence of Decedent 10a. State 10b. County MD Harford		y, Town or Loca	ition		-		1	0d. Inside City Li 1 ☐ Yes 2X	
with the 3a or 28 be noti	I Dire	10e. Street and Number 202 Kane Court	<u> </u>		10f. Zip-Code 21085			10g. Citizer	n of What Coun	try?	
or Ite	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married	 12. Was Decedent Ever in U. Armed Forces? 1 X Yes 2 □ No If Yes, Give 	lt)	as Decedent of H	ispanic Origin? (S an, Mexican, Puerl Specify:	Specify Yes or No to Rican, etc.)	- 14	. Race - Americ Black, White, e	etc.	
iin 72 hours n "natural"; //dedical Exa	Completed b	3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade		(Give kii	nt's Usual Occup nd of work done ONOT use retired	during most of wo	orking	16b. Kind	d of Business/In	Thite dustry	
ified with Hygiene. other thai ent, the N	Be Com	12 17. Father's Name (First, Middle, Last)	Conege (1 4 of 5 f)	Compu	ter Spec		ame (First, Middle		vernmen urname)	t	
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Highene. Important: If Item 27 is marked other than "natural" any injury or other traumatic event, the Medical Exalonce.	To E	Charles Edward 19a. Informant's Name/Relationship (Type	White, Jr.	19b. Mailing	Address (Street	Helen_ and Number or R	Elsie Rural Route Numi	Grat Der, City or		Code)	
		Roberta White / V	20b. F	Place of Disposi		t, Joppa	MD 21 Date		ation - City or To	wn, State	
nit. Pages artment o ortant; If I injury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☒ Donation 5 ☐ Other (Specify) 21. Signature of Figure 1 Service License	An An	atomy Gif	Ets Regist Name and Addre	ry 05/2	23/2011 Anatomy				
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Physician /Medical		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line. STROKE Due to (or as a conseq							Interval Betwee Onset and Dea	
Examiner	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq								
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ath cer ttendin for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregn. 1 Live birth 2 Feta 4 Pregnant at time of c	al death 3	Ectopic pregnand Other (specify) _	sy		23	d. Date of deliv Month	ery Day Yea	ır
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ling Phy I. After this funeral		27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wor M 1	ry at k? Yes 2 □ No	28d. Describe	how injury	occurred		
al or Attendi s after death. Il Director: A ed in by the fi	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - At he building, etc. (Specif	y)			City or To	wn, State)		ral Route Numbe	r,
To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b	edical (29a. Certifier (check only one) 1	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death ation and/or inve	occurred at the ti estigation, in my	me, date and place opinion, death oc	ce, and due to th curred at the time	e cause(s) a e, date and	and manner as place, and due	stated. to the cause(s)	
To th withir To th comp	Me	29b. Signature and title of certifier	Do		29c. Licens	e number	000		signed (Month,		11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALMUS DO

31. Date filed (Month, Day, Year)

NAY 2 4 2011

MAY 2 4 2011

600 North Wolfe St, Baltimore, MD, 21287

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ Month Mary Whitacre May 22 4:00 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death Examiner Baltimore Ivy Hall Nursing Home Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 9 - 8 - 19 18 Months Days Hours 116-09-5541 92 NY Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland Director MD 1 X Yes 2 No Baltimore Dundalk 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or edical Examiner must be Funeral 103 Center PLace 21222 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black. White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates Specify: 3X Widowed 4 □ Divorced Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important. If item 27 is marked other than "na
any injury or other traumatic event". (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 2+ Secretary/Purchasing Commercial Credit Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Harry Gordon Mary Unknown 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lauvenia Poistin-Law <u> 1429 Langford Road, Baltimore, MD 21207</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 5-24-11 Glen Burnie, MD Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Spgcify) 22. Name and Address of Facility 21. Signature of Funeral Bradley-Ashton Funeral Home Willow Spring Road. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ whomen disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Que to for earle consequence of Paremak use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical By Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 1 — Yes 2 — No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day ģ Month Year Pregnant at time of death signed by the a Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy page 1 ☐ Yes 2 ☐ No Yes 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 🖰 No Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA ပ္ 4 Hursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending s after death.

I Director: Af d in by the fu 2 Accident
3 Suicide Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital or A within 24 hours after To the Funeral Dires completed filled in b Medical 1 Decritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b, Signature and title of certif 29d. Date signed (Month, Day, Year) 29c. License number D31464 MD 23111 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N. EUTAW ST Suite 308 BALTIMOREMD 21201 A. HAS Hom I MD 31. Date filed (Month, Day, Year) _ - . Registrar's Signatur State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May 20, Day 2011 1:45 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Sandy Spring Brooke Grove Rehab and Nursing Center Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🛣 M 2 🗆 September Director 92 1918 Washington, D.C. 579-16-2576 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Rockville Maryland| Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20853 United States 4511 Dabney Drive 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give ₩₩.J.T.T. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Divorced 4 Divorced WWII Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) D.C. Government Supervisor Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental H ၉ Health and Ment tem 27 is marked ther traumatic Melville Wilcox Margaret Loeffler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline O. Wilcox / Wife permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to 4511 Dabney Drive, Rockville, Maryland 20853 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) Parklawn Memorial Park May 23, 2011 Rockville, Maryland 21. Signature of Fungral Servina Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, 300 West Montgomery Avenue, Rockville, MD M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine Due to or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by FITCH ANON1 Yes 2 No 3 Probably 4 Ulriknown Division of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 1 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 DNO Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer Natural 5 Pending work? 2 🗌 No 2 🔲 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 1 Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 29b. Signature And title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar NEORGIA

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05 Year 2011 WINEGAN 0:15 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Levindale Nursing Home Baltimore Social Security Number . Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Sept. 29 Funeral 9. Birthplace (State or Foreign 1 M 2 F Months Min. Hours 215 24 5940 Director 98 Sept. Usual Residence of Decedent ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2401 W. Belvedere 21215 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. by 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify Black Completed 3 😾 Widowed 4 🗌 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse'sAssistant 9th City Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Claiborne Liggins Alice Anthony 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn W. Franklin(daughter) 5522 Todd Ave. Balto, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Woodlawn Cemetery May 25,2011 Sign, to e of Funeral Service Licens Cally In Add B. of Schuggs Funeral Home Ε. Preston St. Balto, Md. 23a. Part 1.4 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DMPLICATIONS Physician/ DEMENTIA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ☐ Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş Completed 1 Yes 2 No 3 Probably 4 Unknown this certificate has been siral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1. Natural 5 Pending injury Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral Di

completed filled in Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) S 2011 MYSICIAN 0064533 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEVINDALE CIERIATRIC 2434 W. BELVESERE AVE. BALTINORE ATUNDE 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Raymond Young		State of Maryland / Department of Health and Mental Hygiene 1-For State Registrar Certificate of Death Reg. No.	0111661
Physicia Medical Examin	n/	1. Decedent's Name (First, Middle,Last) Raymond Anthony Young 2. Date of Death Month Day May 19, 2011	Year 0219 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. Cou University Hospital Baltimore	inty of Death
Funeral Director		219-98-8109 1 MM 2 F 29 Yrs. Months Days Hours Min. 2/2/198	9. Birthplace (State or Foreign Country)
Maryland 28a-f show any d at once.	Director	Usual Residence of Decedent 10a. State	10d. Inside City Limits 1
ath with the Mitems 23a or 2		3904 Penhurst Ave 21215 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. R	US A Race - American Indian, Black,
s after death v rral", or item	by Fune	3 Wildowed 4 Divorced in Yes, Give Year 1 Yes 2 Lano specify: Spec	White, etc. Sify: Black
NOTE, MD 21215-0036 sges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If If item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatite event, the Medical Examiner must be notified at once.	Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) For K Lift operator Was	of Business/Industry
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than event, the Medical		17. Father's Name (First, Middle, Last) Ray mond young 18. Mother's Name (First, Middle, Maiden Surna Pamela Que	en
MD 2 nd 2 should alth and M m 27 is m	֓֡֞֞֞֞֞֞֞֞֞֞֩֞֩֞֞֩֞֩֞֞֞֩֞֞֩	Darbare Richardson 4648 Coleherne Rd. B	
₽ E E E E		crematory or other place)	on-City or Town, State 1 time, mD.
		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee Varyn C 10. Signature of Funeral Service Licensee 11. Signature of Funeral Service Licensee 12. Name and Address of Facility Vary Shn C. Green State Stat	
Physician /Medical £xaminer		23a. Part I. Either the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Gunshot Wounds Due to (or as a consequence of):	r heart Approximate Interval Between Onset and Death
	je.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
cecuted and - transit	<u> </u>	Cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): d.	
0, be executed sician and burial - transi	dical	UNPENDED AMENDED	
	žΓ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	e of delivery h Day Year
that the do	y P. J.		ontribute to the cause of death?
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the safter death. at Director: After this certificate has been signed by the funeral director, page 2 should be detach.	Completed	1	3 Probably 4 Unknown 1b. Were autopsy findings available prior to completion of cause of death?
tal Rec	දු මූ	25. Was case referred to medical examiner? 26. Place of Death (Check only one)	1 Yes 2 No
1 of Vit	의.	1 Yes 2 No lossifier 1 Inpatient 2 FR/Outpatient 3 DOA Oute4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occ	
ision Attendii er death. rector: A	Certification:	1 Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Nu	imber or Rural Route Number, City
Divisior 5. Hospital or Attend 2. 4 hours after death Peneral Director: stely filled in by the		4 W Homicide determined (Specify) Local Street 3100 Spalding Ave at Par	rk Heights Ave, Baltimore, MD
To the Hos within 24 h To the Fur completely	GICa	(Check only one) 2 Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and man and or investigation, in my opinion, death occurred at the time, date and place, and manner stated	
	2	29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date s May 19,	igned (Month, Day, Year) 2011
P		30 Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
Stal Registra	-	31. Date filed (Month, Day, Year) 32. Registrar's Signature	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Reg. No.										
Physici										Year	3. Time of Death	
Medical Exami	ner	Mark Zelbo						May 19,	May 19, 2011 1613 hrs			
}		4a. Facility Name (if not institutio	n , give street and n	umber)		4b. City, Town, or L	ocation of D	eath	7.15	County of Dea		
		Suburban Hospital Bethesda							Mo	ontgomery		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ıst birthday)	If Under 1 Year	If Under 24		Birth (MM/DI		Birthplace (State or	
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21215-0 vuld be filed w Mental Hygic marked othe	Be	Daniel Zelb	0		T401 14 31		Mar	<u>ion Kavke</u>	witz	- 0:		
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MD and 2 sho alth and m 27 is		Lisa Zelbo /	Wife	1 00t D		Friendshi		d. Chevy	Chas	e, MD	20815 or Town, State	
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Baltimore, MD permit. Pages I and 2 shu Department of Health and Important: If item 27 is injury or other fraumat		21. Signature of Funeral Service		1002	22	Name and Address of Ward Sage	of Facility	ral Dire	ction	1 Inc		
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Ditta	등	4 Homicide deter	mined (Specify)	Residence				5500 Friends	ship Boule	evard , Che	vy Chase, MD	
Hos 24 hc Fun		(Oncon only	-			rred at the time, date	-					
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use at	Medical		miner:On the basis and manner:		id/or investiga	ation, in my opinion,	death occurr	ed at the time, date	e and place	e, and due to	the cause(s)	
F 3 F 8	Me	29b. Signature and title of certifie	r			29c, License	number		29d. Da	ate signed (M	lonth, Day, Year)	
		within for	- Rub	(່ ອ		O.C.M	I.E.		May 2	20, 2011		
Som	ŀ	30. Name and address of person	· · ·		23a)							
9						timore Street, B	Baltimore,	MD 21223				
S	ate	31. Date filed (Month, Day, Year)		egistrar's Signatur		<u> </u>	<u> </u>					
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2011 May 20, Betty Ruth Zepp 11:10 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 410 Eugene Avenue Ferndale Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Mallonth, Pay Year 1941 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funera! 1 M 2 XF 220-40-8201 7.0 Maryland Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County filed within 72 hours after death with the Maryland event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Ferndale 1 Yes 2 X No 10e Street and Number ō 10f. Zip Code 10g, Citizen of What Country? Funeral items 23a 410 Eugene Avenue United States 12. Was Decedent Ever in U.S. Armed Forces2 1 ☐ Yes 2 Å No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", White Completed 3 XWidowed 4 ☐ Divorced Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve and Mental is marked o ഉ Ellwood Buchman Margaret Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5538 Ashburne Rd., Halethorpe, MD 21227 Deborah Ellis - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Purial 2 X Cremation 3 □ Removal from State Atlantic Crematory May, 24, 2011 Glen Burnie, MD Donation 5 Other (Specify) 2. Name and Address of Facility Ambrose Funeral Home, Inc. Signature era Cervice Licens 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Pregnant at time of death Day signed by the a 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of De 17 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 5 Pending 2 Accident Investigation 1 Yes 2 No the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my color Medical 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) Sign D39505 arkay

Registrar

DHMH 17 Rev 7/2009

State

wed cause or death (Item 23a) (Type, Print) (al Dr, Glan Sumil, MD.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 16614 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Miriam Helen Allison \mathbf{P}^{M} 2011 May 8:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Hebrew Home Rockville Montgomery . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Jan 18 1 ☐ M 2**X** F Months Days Hours Min. Day, Yea **Director** 577-38-8318 82 Washington. D.C Usual Residence of Decedent shov aţ 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 28a-f s Examiner must be notified 1 X Yes 2 ☐ No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral 1306 Abbott Road items 23a 20851 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married 0 Yes 2 X No 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White If Yes, Give "natural", 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Legal Secretary Law Firm Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Samuel Venezky Anna Kraus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jon Robert Wilner/son 2233 Deckman Lane Silver Spring, MD 20906 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 05/26/11 Woodbine, MD 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Service Licen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Ph sician/ disease or condition resulting in death) Breast Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a possecularida of: cause. Enter Underlying Cause (Disease or iinjury Exam or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): as the burial attending physician Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 Yes 2 No Por Month Year 4 ☐ Pregnant : 9 ☐ Unknown Pregnant at time of death 5 Other (specify) 9 Unknown Division of Vital Records, P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? injury Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number muna fazle, mn D0064871 5011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Fazli,

31. Date filed (Month, **MAY 25**

6/21 Montrose Rd Rockville

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 10:25 0 M 2011 Sara Anderson Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Aryndel An Glen Burnic Anna Baltimura Washington Medical Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number **Funeral** (Month, Day, Year) ug. 20 1933 Hours Min 1 M 2 X F 77 239-44-1808 Aug. **Director** Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits at 10a. State with the Maryland Director must be notified 1 Yes 2 No Maryland Anne Arundel Severna Park 10g. Citizen of What Country? 10f. Zip Code 0 10e. Street and Numbe items 23a IISA 320 Stonehouse Drive 21146 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status the Medical Examiner Armed Forces?

1 Yes 2 X No Black, White, etc. ō ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Education event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Mental Important: If item 27 is marked any injury or other traumatic evenoce. 2 Melvin Thompson Louise Nobles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Anderson 320 Stonehouse Drive, Severna Park, MD 21146 (spouse) Date 23 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Metro Crematory Inc. May 2011 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore, Maryland Signatu 22. Name and Address of Facility of Fur eral Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ongestic HEART disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine sician and burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 2 🗌 No this certificate 1 Yes Yes 2 L or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Director: After injury 1 Natural 5 Pending work? 2 No after death. Investigation Accident filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical 1 🗜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number

State Registrar

SACA

Washing ton

Name and address of person who completed cause of death (Item 23a) (Type, Print)

MN, 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Ronald W. Anthony Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospice at Wicomico burs Social Security Number Sex 8. Date of Birth Aug 19, Year) Aug 19, 1948 7. Age (In yrs, last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Hours Min. 1 🛣 M 2 🗆 F Gountry) Maryland **Director** 214-54-7865 62 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No MD Worcester Ocean City 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 206 N. Division Street #6 21842 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Completed by 1 Never Married 2 Married 1 Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: white 3 Widowed 4 X Divorced Year or Dates It of Health and Mental Hygiene.

If item 27 is marked other than "natur or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 printer newspaper Be unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 206 N. Division Street #6 Ocean City, MD 21842 Donna Adkins/adopted sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of h
Important: If ite
any injury or ot Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) in state Signature of Fundamental Ronal I d State Anatomy Board 655 W. Baltimore Street art 1. Enter the disease, or compilations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Pnysician Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 2 X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 📉 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA HOSPIER 4 ☐ Nursing Home 5 ☐ Residence 6 A Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred injury Natural Natural 5 Pending within 24 hours after deaun.

To the Funeral Director: Aff Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Signature and title of certifier 29c. License number 50. Name and address of person who completed cause of death (Item 23a) (Type, Print) BELLOSO 5302 CHINABERRY DR., SALISBURY MD 21801 GREGORIO

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

MAY 25

State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Margaret L. Armstead Month Physician/ 9:20 PM 2011 Medical 4a. Facility Name (if not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore HOSPITAL Himork 8. Date of Birth (Month, Day. 7. Age (In yrs. last birthday) 71 Yrs. If Unde If Under 24 Hrs. 9. Birthplace (State or Foreign 068-32-7692 **Funeral** (Month, Day, Year) 05/18/1940 1 🗆 M 2 🕮 Hours Min Director Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Examiner must be notified at Director Baltimore MD 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What C USA 5201 Beaufort Avenue 21215 Funeral items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ö 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 American Indian If Yes, Give Year or Dates 1 Yes 2 No Specify. "natural", enow as margaret 3 Divorced 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Own Home Homemaker permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Arthur Jackson Julia Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5201 Beaufort Ave., Baltimore, MD Daniel Armstead/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Final Journey Crem. 5/25/2011 Woodbine, MD 22. Name and Address of Eacility
Maryland Cremation Services 21. Signature of Funeral Service Licensee Dorota Marshall PO BOX 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and eath Immediate Cause (Final una ੈ hysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami and -trar Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Year Month Pregnant at time of death led by the a 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform has within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director management and according to the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1X Natural injury 5 Pending M 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day Year, 18 Boll death (Item 23a) (Type, Print)

0 6565 N. Name and address of person who completed cause of N. Charles St # 203 Baltomore MD 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 1 - State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 840AM Physician/ hugo Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SEasons Hospice Baltimore Randallstown MD If Under 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** ocial Security Number 053 – 20 – 5039 1 🗆 M 2 🔀 🕱 84 Months Days Hours Min (Month Day, Yea 4/12/2 MM Yrs Director 28a-f shov 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location **Funeral Director** filed within 72 hours after death with the Maryland ems 23a or 28a-f sh r must be notified a Baltimore MDBaltimore 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 3702 Buckingham Rd 21207 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Examiner Armed Force Black, White, etc. þ P. 1 Never Married 2 Married 2XEXNO ☐ Yes White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: "natural" Completed 3 Widowed 4 X invorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Entertainment the Singer 2+ other Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) alth and Mental H 27 is marked of r traumatic ever permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. ည Waid Ira Genivive Davenpørt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Fate, Zip Code) Nancy K. Fagerstrom /Daughter 8611 Indies Drive, Hudson FL 34667 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2XXCremation 3 Removal from State Ardent Crematory 5/24/11 Hanover MD 4 Donation 5 Other (Specify) Signature Funeral Service Licensee V1CLor Doda L. Stevens Funeral Home Fort Avenue, Baltimore, 16 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Physician/ he disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed physician and strans Due to (or as a consequence of): Physician/Medical P.O. Box 68760 use as IF FEMALE: attending yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte Month Day 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an ate has bage 2 s autopsy death? 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence Hospital ၀ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral . Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred s after death. Natural injury 5 Pending 1 Yes 2 No Accident Investigation the 1 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) the Hospital within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (

State Registrar 31. Date filed (Month; Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 444 A Key 01 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis Sex 1X M 2 G F If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) Funeral Months Days Hours Min West Virginia (Month Bay Yasr) 67 1943 Director 212-42-2017 Usual Residence of Deceden or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location the Maryland Examiner must be notified at Director 1 🗆 Yes 2 🕇 No Maryland Pasadena Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a death with USA 21122 278 10th Street items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Bace - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates Specif White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Computer Technician the Medical 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than any injury or other traumers. Elementary/Seconday (0-12) College (1-4 or 5+) US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ella Bandy Edward H. Cocus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2520 Ayr Court Crofton, MD 21114 Anthony M. Busciglio Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May 28 cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Baltimore, MD 2011 Metro Crematory, Inc. 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility
Stallings Funeral Home, P.A. 21. Signature of Funeral Service License 3111 Mountain Road Pasadena Maryland 21122201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myocardial cure disease or condition Medical resulting in death) Examiner onary arter Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami physician and s the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 ding p IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Dav Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ End Stage renal disease 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an or Attending Physician: The law page 2 s autopsy performe has certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Yes 1 Inpatient 2 R/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural injury 5 \square Pending o 24 hours after death.

Funeral Director: After the function of the function 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D57531 m.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8601 Suite 204. Millersville

Registrar DHMH 17 Rev 7/2009

State

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5 2011

31. Date filed (Month, Day, Year)

VeTerans Hwy.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 15 Physician/ James Edward Billups 2011 130A M May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death
Baltimore 4b. City, Town, or Location of Death 69 Wiltshire Road Essex 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Yea Aprill 9 **Funeral** 9. Birthplace (State or Foreign 232-46-6466 1 🔀 M 2 🗆 F Months Min. Hours 78 Director ″,193B Alabama Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Essex Baltimore MD 1 Tes 2 XNo 10f. Zip Code 21 221 10e. Street and Number 10g. Citizen of What Country? by Funeral 69 Wiltshire Road USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married □XYes 2 □ No Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Beth Steel Operator Crane: 7th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Willie Edward Jacks ပ Roy William Billups 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code)
69 Wiltshire Road Balto. MD 21221 Helen B. Billups /wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Holly Hill Cemetery 5/19/11 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ monary disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last signed by the attending physician and dedetached for use as the burial-trans Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available this certificate has autopsy prior to completion of cause of death? performe 1 Yes 2 No Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🛂 No Other: ပ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Registrar's Sign

Year)

25 2011

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 1 State of Maryland / Department of Health and Mental Hygiene

		I- For State Certificate	e of Death	Reg.				
Physicia Jedical Examin	n/	1. Decedent's Name (First, Middle,Last) Marcellus Brown		2. Date of Death Month Day Year May 20, 2011 3. Time of Death 2119 hrs				
		4a. Facility Name (if not institution, give street and number) University Hospital	4b. City, Town, or Location of Death Baltimore	9	4c. County of Death N / A			
Funeral Director		5. Social Security Number 215-17-9835 6. Sex 26 7. Age (In yrs. last birthda 26	MM/DD/YYYY) 9. Birth Foreign Cour	place (State or MD ntry)				
nd show any ice,	Usual Residence of Decedent 10a. State							
eath with the Maryland items 23a or 28a-f show hat be notified at once.	Director	10e. Street and Number 5913 Radecke Ave - Apt. J	10f. Zip Code 21206		Citizen of What Count USA	ry?		
- 5 B	by Funeral	Armed Forces? Married Armed Forces?	3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No specify: 2 dednt's Usual Occupation (Give kind of w.)	Rican, etc.)	14. Race - Americ A Trical Specif Americ	n ican		
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner	Completed		ing most of working life. DO NOT use retir		Taxi			
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	8	17. Father's Name (First, Middle, Last) William Brown	-	rita Br	own			
MD 21 and 2 should alth and Me m 27 is ma	-[Jose Marquerita Brown/Mother		-Apt.J,	Balt., MD	21206		
or Her tr		1 Burial 2 Cremation 3 Removal from State Bayvio	ew Crematory	5/11 E	Balt.,MD			
Baltimo permit. Page Department Important: injury or ott			22. Name and Address of Facility Har 5126 Belair Rd,			S PA 5105		
Physician /Medical /xaminer		23a. Part I. Enter the disease, or complications that caused the death. Do not e failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		respiratory arrest	, SHOCK, OF HEAR	Between Onset and Death		
-de	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):						
d sit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):						
e executed cian and nral - transit	/Medical E	d. AMENDED 23a,27,28a-f	,per me,g916 6-7-1	l sm				
lox 68 leath certi e attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Pregnant at time of death 5	Fetal death 3 Ectopic pregna Other (Specify)	ncy	23d. Date of delivery Month D	ay Year		
P.O. E res that the d signed by the be detached	<u>a</u>	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		acco use contribute to t	ably 4 Unknown		
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death. 1 Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	Completed			24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of S		
ician: The certificate rector, page	8	25. Was case referred to medical examiner?	26.Place of Death (Check					
hysic al dire	ા	1 Yes 2 No Inpatient 2 ER/Outp	atient 3 DOA Outer 4 Nursing of Injury 28c. Injury at Work?	g Home 5 Re				
ion of tending Ph. eath.		1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation fd 5-20-11 fd 3	:23 pm 1 Yes 2 No	subject	shot self			
Divis spital or At hours after or neral Direc y filled in by	Certification:	3 Suicide 6 Could not be determined (Specify) Street	, street, factory, office building, etc.	or Town, State Baltimor	eet and Number or Rur te) 4400 B1k. e, Md.	Pen Lucy Rd		
To the Hosy within 24 ho To the Fun completely f	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death one) 2 Medical Examiner: On the basis of examination and/or investigated in the control of the basis of examination and/or investigated.	estigation, in my opinion, death occurred a	t the time, date an	id place, and due to the	cause(s)		
H × H 5	ž	29b. Signature and title of Pertifier	29c. License number O.C.M.E.		29d. Date signed <i>(Mon</i> May 21, 2011	th, Day, Year)		
pent OCHE		30. Name and address person to completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner	900 W. Baltimore Street, Baltin	nore, MD 212	23			
Sta Regist	ate rar	31 Date filed (Month, Pay Year) 32. Registrar's Signature	te s					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day} 2011 22 3:28 A.M Lucille Bucklen Belsterling May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, 1 □ M 2XXF Months Days Hours Min. h, Day, Ye 14, Director 212-32-6418 77 Yrs. May Tennessee Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene, Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore 1 Yes 2 XXVo Baltimore 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? United States Funeral 414 South Marlyn Avenue 21221 of America Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Yes 2XXNo Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: 3 Widowed 4XXDivorced Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Secretary Bethlehem Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Edward Bucklen Lucille Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna L. Tipton (Daughter) 15123 Old Hanover Road, Upperco, MD 21155 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State retery, crematory or other place)
Faiths Crematory
& Chapel 1 Burlal 2XXCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2Õ1 i Manchester, Maryland 21. Sonature of Fune by ey (ce) 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 charmil Drive, Manchester, MD 21102 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ COL JUN 2011 disease or condition 11DMC Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl for use as t IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s has autopsy performed? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital: 2XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred Natural iniury 5 Pending Accident M Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Dame and address of person who completed cause of death (Item 23a) (Type, Print) ausorta 31. Date filed (Month, Day, Year)

State

Registrar

MAY 25 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 22, 2011 8:20 PMChristopher E. Cramer, III Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville Casey House If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 1 🗶 M 2 🗆 F Hours oct 5, 1957 California **Director** 243-06-5456 53 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 X No <u>Maryland</u> Montgomery Silver Spring 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a United States <u>311 Bryants Nursery Road</u> 20905 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. other traumatic event, the Medical Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed 3 Divorced 4 Divorced Year or Dates:1977-1979 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales/Delivery Napa Auto Parts Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental မ Naomi Barber <u>Christopher Cramer, Jr.</u> and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shment of Health a 311 Bryants Nursery Rd. Silver Spring, MD 20905 <u>Naomi B. Cramer / Mother</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important; If ite any injury or ot Date cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Journey Crematory 5/24/2011 Woodbine, Maryland 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 21. Signature of Funeral Service License MO1251 23a. Part 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Betweer Immediate Cause (Final Onset and Death [⊿]Physician/ disease or condition resulting in death) Lung Cancer Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to for as a nonsectionne of cause. Enter Underlying Cause (Disease or iinjury Exami attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an eral Director: After this certificate has filled in by the funeral director, page 2 s death? 2 🔀 No 1 ☐ Yes 2 🔀 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 X Natural injury 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide within 24 hours a Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, May 23, 2011 D37142 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Rd. Rockville, MD 20855 Coleman, M.D. State

DHMH 17 Rev 7/2009

Registrar

5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 18, 2011 9:17 May \mathbf{P} M Medical <u>Bob Chih–Pao Chuang</u> 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 620 Great Falls Road Montgomery Rockville Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Year) 92<u>6</u> 1 🗶 M 2 🗆 F Months Days Min. Hours sept 2 **Director** Yrs China 578-80-8922 84 Usual Residence of Deceden an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 □ No Rockville Maryland Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 620 Great Falls Road 20850 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced Specify: Year or Dates Chinese 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Motel <u>Owner</u> traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Yuei-Chuan Chuang (unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health 620 Great Falls Rd. Rockville, MD 20850 <u> Difan Chuanq / Son</u> injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State 4 Donation 5 Other (Specify) Journey Crematory 5/20/2011 Woodbine, Maryland Signature of Funeral Service Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Onset and Death years Immediate Cause (Final Physician/ disease or condition resulting in death) Vascular Dementia Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examin or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a sthe burialcal Division of Vital Records, P.O. Box 68760 Physician/Medi use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown for Month Dav Pregnant at time of death Year signed by the a g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown been si should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed After this certificate 1 Yes 2 X No director, 25. Was case referred to medical Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred s after decral Director; Aftr (Month, Day, Year) X Natural injury 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide within 24 hours after de

To the Funeral Directo

completed filled in by ti 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) May 19, 2011 D37142 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Coleman, M.D 1355 Piccard Dr. Rockville, MD 20850 31. Date filed (Month, Day, Year) State 25 2011 Registrar

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State of Maryland / Department of Health and Mental Hygiene. State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2011 5:12 AM OR Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2300 ROAD GOLUPSKI BALTIMORE ESSEX Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 🗆 F Days Hours Min. MEXICO **Director** 37 Usual Residence of Decedent "natural", or items 23a or 28a-f shovicial Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2X No MD Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2300 Golupski Road 21221 Mexico Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2X No 14. Race - American Indian, Black, White, etc. Completed by 1 X Never Married 2 Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates ¹X Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Mexican Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene, Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) Farmer Farming Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Pedro Collazo Livia Citala 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Zahradka, III/friend 2300 Golupski Rd. Essex, MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematorly 05/24/11 Woodbine, MD of Funeral Service Signat Going Home Cremation Service P.O.Box 784 Beverly L Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each lin Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ph sician/ monoma Medical sequen > of): 6 mouths **Examiner** Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death Day 1 Yes 2 No ed by the a detached t 9 Unknown Division of Vital Records, P.O. s been signed by should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 s autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After th completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce 002 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ROBIN UJOS 24,2011 7:29 AM Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BURDIE BALTIMORE WASHINGTON MEDICA GLEN ANNE ARUNDEL LENTER 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🛭 F Days Hours Months Month Day Year 1965 Director Maryland 217-82-5204 Usual Residence of Decedent or 28a-f show notified at with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🖁 No Maryland Anne Arundel Pasadena 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 21122 USA 117 Lake Shore Drive hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 → No Specify: SpecifyWhite Completed 3 Widowed 4 X Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Restaurant Manager 10 Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e COEN, ROBIN Robert Riidiger Joann Steinberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Burns (Friend) 117 Lake Shore Drive Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) May 25 20c. Location - City or Town, State 1 🗌 Burial 2 🔀 Cremation 3 🔲 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 2011 Metro Crematory, Inc. 22. Name and Address of Facility
Stallings Funeral Home, P.A. 21. Signature of Funeral Service Libense 3111 Mountain Road Pasadena Maryland 21122201 23a. Part 1. Enter the disease, or compl cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. shock, or heart failure. List only or Interval Between Immediate Cause (Final nset and Death Physician/ disease or condition resulting in death) AIGOMUSUS 2 DAYS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine one to (or as a consequence of, Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran: that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🔀 No Pregnant at time of death Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ COPD Completed 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 **N**Nc 1 Yes 2 No Yes 25. Was case referred to medical Certificate; To Be 26. Place of Death (Check only one) 1 Yes 2 🔼 No Other: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a Certifier 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Colubbrana Jasa Grang roce, MD D008511A MAY 24, 2011 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 HOSPITAL DRIVE, GLEN BURNIE, MD 20161 GUILLERMO JOSE GIANGRECO

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State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death BESSIE Physician/ 2^{P3y} LUCILLE CANESTRARO MAY 2011 12:15pM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death STELLA MARIS HOSPICE BALTIMORE TIMONIUM Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Months 218 42 7460 0173771945 66 MARYLAND Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD HARFORD JOPPA 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 390 ENFIELD ROAD 21085 USA 11, Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 XMarried Completed by 1 Yes If Yes, Give 2X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHITE "natural", 3 \square Widowed 4 \square Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) MANAGER DENNY'S REST. 10 marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည MILTON J. WITTLER BESSIE I. ELLIOTT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 s ment of Health 390 ENFIELD RD JOPPA, GUY J. CANESTRARO/HUSBAND MD 21085 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State METRO CREMATORY 05/25/11 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Fune al Service Licenses 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani CONGESTIVE HEART FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 1 Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 27. Manner of Death 28c. Injury at work? Certificate: 28a. Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 🗶 Natural 5 Pending injury 1 Yes 2 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated **X** Certifying Nurse Practical of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title o 2011 30. Name and address of persor who completed cause of death (Item 23a) (Type, Print) JONES, 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 Date filed (Month, Day, Year, State MAY 25 2011 Registrar

DHMH 17 Rev 7/2009

CANESTRARO

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ginger Burns C	rona	uer St; 1- For State Registrar	ate of Maryla		artment of <i>rtificate of</i>		Mental H		eg. No. 20	11 1652
Physici Medical Exam	an/ iner	Decedent's Name (First, Middle GINGER	a,Last) BURNS	5	CRC	NAUER		2. Date of Dea Month May 19, 2	Day Year	3. Time of Death 0400 hrs
A		4a. Facility Name (if not institution 501 Potomac Avenue	n, give street and nur	mber)		4b. City, Town, or L Rosedale	ocation of Death		4c. County of E Baltimore	
Funeral Director	tor 212 CO FEEE				last birthday) 59 Yrs	If Under 1 Year Months Days	If Under 24Hrs Hours Mir	1.	th(MM/DD/YYYY) S	9. Birthplace (State or oreign Country) MD
y.		Usual Residence of Decedent 10a. State 10b. County		Inc. City	, Town or Locat				-1752	10d. Inside City Limits
and show as	ō		BALTIMORI		, TOWN OF EDGE	ROSEDA	LE			1 Yes 2 No
with the Maryland ns 23a nr 28a-f shro be notified at once.	Director	10e. Street and Number 501 POTOMAC	AVENUE	10f. Zip Code 21237				1	0g. Citizen of What $U . S$.	•
r death nr iter must	Funeral	11. Marital Status 1 Never Married 2 Mark	Armed Fo	2 🔀 No	lf Y	s Decedent of Hispones, specify Cuban,	Mexican, Puerto		White, e	merican Indian, Black, tc. WHITE
ours afte stural",	þ	3 Widowed 4 Dive	orced or Dates: or Dates:		16a. Deceden	Yes 2X No	n (Give kind of		Specify:	
5-0036 led within 72 hours after Hygiene. In ther than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12) 1 2	College (1-	4 or 5+)	during m	HOMEMA	KER			1 HOME
21215-0036 vald be filed within 7 Mental Hygiene. marked ather than c event, the Medica	Be	17. Father's Name (First, Middle, UNKNOWN	,	HOLL			JEWEL			IKNOWN)
	L L	19a. Informant's Name/Relations				Address (Street a			nber, City or Town, S ALE, MD	State, Zip Code) 21237
imore, MD 2121 Pages I and 2 should be fi rent of Health and Mental ant: If item 27 is marked or nither traumatic event,		20a. Method of Disposition 1 Burial 2 Cremation	3 Removal fro	m State	crematory or oth			Date	20c. Location - Ci	
Baltimore, MD permit. Pages I and 2 sh Department of Health and Important: If item 27 is injury or arther traumat		Donation 5 Other Sp 21 Signature of Funeral Service		M	22. N	REMATOR	f Facility CV	21-201 ACH/RO	SEDALE E	SVILLE, MD FUNERAL HOM
m ឧក្សាភា Physician		23a. Part I. Enter the disease, or		used the death		11 CHES				Approximate Interval
/Medical Examiner		failure. List only one cause of Immediate Cause (Final disease or condition resulting in death)	a Mixed d			on (Morph	ine Car	isoprodo	ol Diazepa	Between Onset and Death
		Sequentially list conditions,	Due to (or as a							
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a							
e be executed ysician and burial - transit	al Ex									
50, te be exertise by the second of the seco	a. AMENDED 23a,27,28a-f,per me,g916 6-24-11 sm [23d. Date of pregnancy] [23d. Date of pregnancy]								23d. Date of de	iven
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unk	1 Live bit	rth int at time of de	2 Fet	al death 3	Ectopic pregna	incy	Month	Day Year
ires that the cosing signed by the detached	by Ph	Part II. Other significant condition	ons contributing to	death but not r	esulting in the u	nderlying cause giv	en in Part I.			e to the cause of death? Probably 4 Unknown
ords, F w requires s been sign should be								24a. Was a	an 24b. Wer	e autopsy findings available
of Vital Records, ng Physician: The Jaw requir Wher this certificate has been s meral director, page 2 should i	completed							autop perfor 1 V Yes	med? deal	to completion of cause of h? Yes 2 No
Vital Rec bysician: The this certificate	o Be C	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1	patient 2	ER/Outpatient	- IO	Death (Check		Residence 6	Other Scene
ling Phy After th	-1	27. Manner of Death	28a. Date o		28b. Time of Ir	ajury 28c. Injury	at Work?	28d. Describe h	now injury occurred	
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	2 Accident Invest 3 Suicide 6 Could	not be 28e. Place	-	fd 3:34 ome, farm, stree	am 1 Ye t, factory, office bui	s 2 X No	Unknown 28f. Location (S	Street and Number of	r Rural Route Number, City
E Hospital 24 hours Funeral etely fille	cal Cer	29a. Certifier (Check only 1 Certifying Ph	ysician: To the best		ge, death occur			due to the caus	e(s) and manner as	
To th withir. To the	Medic	one) 2 Medical Example 29b. Signature and title of certifier	niner:On the basis of and manner sta		ind/or investigati	on, in my opinion, o		it the time, date a	and place, and due 29d. Date signed	
		Affler Se	sie G. M.	D		O.C.M	.E.		May 19, 2011	
Ø		30. Name and address of person Melissa Brassell, MD	who completed cause Assistant Med			. Baltimore Str	eet, Baltimo	ге, MD 2122	3	
St Regist	ate	31. Date filed (M5nth, Day Year)	32. Reg	istor's Signat.	ure Wald					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2011 Year $\stackrel{\text{Month}}{\text{MAy}}$ 11:20 DM Physician/ 20 George J. Comeau Medical 4b. City, Town, or Location of Death ESSEX 4c. County of Death
Baltimore 4a. Facility Name (if not institution, give street and number) Examiner 418 Theresa Avenue 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Aug. 25, 1933 If Under 24 Hrs. Hours Min. If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 216-30-5619 1 🙀 M 2 🗆 F 77 Yrs **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10b. County 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director Essex 1 Yes 2 No MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21221 418 Theresa Avenue USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces 1 Never Married 2 Married 1 □XYes 2 □ No þ Maryland 21215-0036 White 1 ☐ Yes 2 🙀 No Specify: If Yes, Give 3 XVidowed 4 Divorced "natural". Completed Year or Dates Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) GM Auto Worker the 11th traumatic event, Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 11 and 2 should be file of Health and Mental Fitem 27 is marked of Violet Archie Comeau 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 338 Torner Road Baltimore MD 21221 19a. Informant's Name/Relationship (Type, Print) Robert Kaczmarczyk /son other Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a Method of Disposition permit. Page 1 a Department of H Important: If ite any injury or ot Burial 2 Cremation 3 Removal from State Baltimore MD Parkwood Cemetery 5/24/11 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Funeral Service Licensee Connelly Funeral Home of Essex 23a. Par 1. Enter the disease, opcomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List pnly one cause on each line. Interval Between Onset and Death Immediate Cause (Final Vascular Physician/ dementa disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner trake Sequentially list conditions. Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23d. Date of delivery 23b. Was decedent pregnant Month Year Day in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hospital or Attending Physician: The law requires t 24 hours after death. Funeral Director: After this certificate has been sign pressur Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an choles terol autopsy performed? Yes 2 No disease artery Caronary 25. Was case referred to medical 26. Place of Death (Check only one) Be **Division of Vital** examiner? Hospital: Other: 27 No 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 27. Manner of Death injury 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D0051349 mi 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Square Dr

9101

F-V. Deza

31. Date filed (Month, Day, Year)

Franklin

Ste 205

Bolhmone MD 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. hend #8 Per FH G916 6/13/2011 Jh State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Y Year 9:21 PM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 1 Year If Under 24 Hrs. 8. Date of Birth 198 1960. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Unde **Funeral** 1 0 44 2 D F Hours Min Months 400 Yrs **Director** Usual Residence of Decedent shov 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f OWSON 1 Yes 2 No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral Ues Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White etc ŏ þ 1 Never Married 2 Married 2 🗌 No Maryland 21215-0036 1 Yes 2 No Specify "natural", Specify. 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) Give kind of work done during most of working life DO NOT use retired permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumation. Elementary/Seconday (0-12) College (1-4 or 5+) TU Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 70 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State etery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 1-2011 owing mices 4 Donation 5 Other (Specify) ture of Funeral Service Li 22. Name and Address of Facility 23a. Fac.1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or frent failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ GRAM NEGATIVE disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** YEARS RRHOSIS Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-transit STORY SUBST ANCE that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Box 68760 nding parse as t IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No the 1 | Yes 2 | 9 | Unknown Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by IABETES To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Division of Vital Records, MELLITIS 2 No 3 Probably 4 Unknown Completed PANCREATI 24a. Was an 24b. Were autopsy findings available prior to completion of cause of CHRONIC autopsy performe death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: Certificate: To 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 6384 21204 and address of person who completed cause of death (Item 23a) (Type, Print) DWARDS 601 MD m State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death Rea. No 1. Decedent's Name *(First, Middle, Last)* Robert Lee Clark 2. Date of Death 3. Time of Death Physician/ Month 7:19AM mars Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Prince Georges Examiner Doctors Hospital Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ★ M 2 □ F Days 435-66-5767 Months Hours Min. 03 - 02 - 1945 66 Director Louisanna Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Prince Georges Hyattsville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5610 Gallatine Place 20781 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Completed by Black, White, etc. 1 Never Married 2 Married Specify: Black 1 Yes 2 No Specify: 3 Widowed 4 Divorced If Yes, Give Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Self Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Clark Sr. Celice Mahoney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20747 Maria Clark / Daughter 1958 Rochell Ave Apt. 716 Forestville, MD 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 05/217/201120c. Location - City or Town, State 20b. Place of Disposition (Name of Riverdale Crematory Riverdale MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Dunn&Sons 5635 Eads St. NE Washington DC 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of):
Diabetes Mellitus Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Examine Due to (or as a consequence of): Hypertension Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year Pregnant at time of death Unknown signed by the at be detached for 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed plnous 24b. Were autopsy findings available 24a. Was an page 2 s has autopsy
performed?

Yes 2 1 No prior to completion of cause of death? After this certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical director. Be 26. Place of Death (Check only one) 2 X No 1 Yes Other: မ 1 Natient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation hours after death filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) To the Hospital within 24 hours a To the Funeral I Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотріете (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and a second and a Certifying Nurse Praction of Talky and a fifty knowledge 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MDD53718 5/19/11 vous on 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Thomas Hansson 8118 Good Luck Road Lanham, MD 9 20706

State

Registrar

31. Date filed (Month

2 5 2011

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:12 PM 4a. Facility Name (if not institution, give street and number)
6710 Carroll Highlands Medical or Location of Death Sykesville **Examiner** Carrot Death 1 Road Social Security Number 216-18-7251 If Under 1 Year Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Hours Min 1 17087 1921 Yrs. VA **Director** Usual Residence of Decedent show 10a. State th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Sykesville MD Carroll 1 Yes 2X No 10f. Zip Code 21784 10e. Street and Numbe 10g. Citizen of What Country? Funeral 6710 Carroll Highlands Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. Ď 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home should be filed with h and Mental Hygien 7 is marked other tl Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Syrname Marie J. Jester 2 Arthur Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) 6710 Carroll Highlands Rd., Sykesville, MD permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other tra Charlyn Wentz / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2XX remation 3 ☐ Removal from State 5/23/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crem. 22. Name and Address of Facility Maryland Cremation Services 21. Signature of Funeral Service Licensee Dorota Marshall Box Baltimore, MD 21203 1413, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ una disease or condition Medical resulting in death) ue to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed should been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy this certificate has page 2 performed? Yes 2 N 2 No 1 Yes 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) examiner? 1 Tes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After Natural 2 Accider 5 \square Pending injury work? death. 2 🗌 No M Accident Investigation 24 hours after death Funeral Director: / filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. pleted (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I only one 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 20 eted cause f death (Item 23a) (Type, Print) 3. Registrar's Signature 31. Date filed (Month, Day, Year State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20**11** William Richard Fuhr May 2000 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cecil Union Hospital Elkton Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday **Funeral** Dec. 28,1937 1 🛛 M 2 🗆 F Hours Min 73 219-26-6629 Maryland Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Cecil Elkton 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21921 1 Price Drive U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Equipement Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ William Russell Fuhr Eleanor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
24 Ashlar Hill Court, Baltimore, Maryland 21234 Frances Cipriotti 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State Ardent Cremation, Inc. 5-20-11 4 Donation 5 Other (Specify) Hanover, Maryland 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licenses michael 6009 Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ Chronic obstruction /whow AR disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Completed by Physician/Medical Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the attending physician and hed for use as the burial-transit · Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a, Was an this certificate has ral director, page 2 autopsy 1 ☐ Yes 2 ☐ No filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Yes 2 No ဂ္ ER/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Dear 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No s after death. 28d. Describe how injury occurred 1 Natural 2 Acciden injury 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier b. r. wonde of who 5/18/11 00065733 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ELICION, MO 21921 NARAYAJA RAS V. PULA A E. HIGH street 126 State 5 Registrar DHMH 17 Rev 7/2009

ORIGINAL

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			State Registrar			Cer	tificate o	Death			Reg. No	20		161	634
Р	hysicia	n/	1. Decedent's Name (First, Middle BERNAL)	, Last)	Fo	CCF	, 70			2. Date of Do	eath Da 2	¥	Year	3. Time of 2 21	•
· · · · · · ·	Medic Examin		4a. Facility Name (if not institution)			- 6 20	4b. City, Town		of Death	01			of Death	1	
2		C.	Anne Arundel Me	dical Cent	ter	_	Annapo				An	ne A	runc	lel	
	uneral rector		5. Social Security Number 268–18–6275	6. Sex 1 M 2 □ F	7. Age (In yrs. 16 91	as <i>t birthday)</i> Yrs.	If Under 1 Yes Months Day			8. Date of Bi (Month, D Jan 3,	irth ay Year) 1920		g. Birth Coul Ohic	place (State or ntry)	[•] Foreign
pu	how at	ř	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside Cit	y Limits
Maryla	8a-f s tified	Director	MD Anne A	rundel	Ann	apolis								1 🗆 Yes	2 X No
Z I Z I 3-0030 Within 72 hours after death with the Maryland olene.	a or 2 be no	al Di	10e. Street and Number				10f. Zip Cod	•				tizen of \	What Cou	ntry?	
th wit	ms 23 must	Funeral	7101 Bay Front		dent Ever in U.S	3 112 1	21403 Was Decedent o	Hispanic (rigin? (Sp	ecify Ves or No	USA	14 Poc	o Ameri	can Indian,	
er deg	or ite miner	by Fi	11. Marital Status 1 ☐ Never Married 2【 Marr	Armed For	ces? 2 No	'	f Yes, specify Co	ıban, Mexic	an, Puerto	Rican, etc.)			ck, White,		
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within diene.	the N		Elementary/Seconday (0-12)	College (1- 5+	4 or 5+)	l .	Office	*			US	S Navy			
be filed ental Hv	event	To Be	17. Father's Name (First, Middle, L Bernard William							ne (First, Middle, Maiden Surname)					
Maryland 12 should be file alth and Mental H	mark		19a. Informant's Name/Relations			19h Mailir	na Address (Stre				Mittendorf Hayta Number City or Town State Zin Code				
J NG Id 2 sh id 2 sh	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Mary Frese/wife			7101	Bay Fro	nt Dri	lve A	nnapoli	Route Number, City or Town, State, Zip Code) inapolis, MD 21043				
Jore, Je 1 and It of Hea	or oth		1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place)							Date	_ '				
partition permit. Page 1	ortant: injury		4 ☐ Donation 5 ☐ Other (5		/ Fin		rney Cr						ne, M		
Dep Per	any ir		2 Pull L	Hall	e MO1		ing Hom verly L								1029
			23a. Part 1. Enter the Jisease, or shock, or heart failure. List of	complications that conly one cause on ear	aused the deat	h. Do not ent	er the mode of d	ying, such a	s cardiac	or respiratory a	arrest,			Approximate Interval Bety	e ween
	sician/		Immediate Cause (Final disease or condition	E a. E	ndst	age	Conge	twe	He	art fa	lun	_		Onset and D	eath
4	edical ıminer		resulting in death)	Due to (d	or as a consequ	uend of):	, t	lm +						Y EX	725
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oo/ou	g phys as the	Medi	IE EENALE.	- a											
OX OX	attending physiciar for use as the burid	ian/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		Birth 2 🗌 Feta	aldeath 3	Ectopic pregn				1		ate of deli-		/ear
e dear	the at	Physician/Medica	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregr 9 ☐ Unkn	nant at time of o	death 5 L	Other (specify,						J. 11.11	Duy	ou.
that #	been signed by the should be detached	by Pt	Part II. Other significant condition	ns contributing to de	eath but not res	sulting in the u	ınderlying cause	given in Pa	rt I.	23e. Did	tobacco	use cont	ribute to	the cause of de	eath?
CJ ,	en sig ould bi					_				1 🗆	Yes 2	□ No	3 \square Pro	obably 4	Jnknown
e faw require	has be e 2 sh	Completed								24a. Wa:	s an opsy formed?			opsy findings a ompletion of c	
- ₽	ficate or, pag		25. Was case referred to medical				26	Place of De	ath (Chac	1 🗆 Yes	2 N			2 🗆 No	
VILCII ysician:	is certi	To Be	examiner? 1 Yes 2 No	Hospital:	Inpatient 2 🗆	ER/Outpatie	1/)thor:		ome 5 \square Res	sidence (6 🗌 Oth	er (Specit	···· iy)	
5 g	After this certificate has funeral director, page 2 s		27. Manner of Death Natural 5 Pendir	28a. Date o		28b. Time o injury	28c. Ir W	jury at ork?	_	28d. Describe	how injur	ry occurr	red		
VISION OF or Attending P fter decth.	rector A by the fu	Certificate:	2 Accident Investi	gation not be	of Injuny - At he	ome farm str	M 1 eet, factory, office	Yes 2	□ No	28f Location	(Street an	nd Numh	er or Rur	al Route Numb	ner
al or A	l Direc		4 🗔 Homicide determ		ng, etc. (Specify		ect, ractory, orne	.0			own, State		er or riare	ir rioute rrainie	OI,
Division of vital necolus, r.O. bux 00/00 for the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.	To the Funeral Dir completed filled in	Medical	29a. Certifier Certifying	Physician: To the be Examiner: On the basi	est of my know	ledge, death	occured at the ti	me, date an	d place, a	nd due to the o	ause(s) a	nd mann	er as stat	ed. ause(s) and ma	nner stated.
the lithin 2	orthe F	Me	only one) 3 Certifying 29b. Signature and title of certifier	Nurse Practioner: 1	To the best of m	y knowledge,	death occurred a	t the time, da	ate and pla	ce, and due to	the cause(s) and m	anner as s	btated. Day, Year)	
F 3	Þö		Amila	- ato	natu	1	0	2/14	38		1	lac	124	201	1
XI			30. Name and address of person	who completed caus		1 23a) (Type, I	Print) DEM	ENIE	Hus	W24/	400	7	M	22-140)
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	Registra		MAY 25	2011 /2	wa k	7. 100	Ver								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item#5, per fh, g917 7-11-11 sm State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Month Yeer 1:55 PM Janet L. Frazier May 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Genesis Multimedical Center TOWSON Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F Director 75 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits or than "natural", or Items 23a or 28a-f show The Medical Examiner must be notified at 1 ☐ Yes 2 ▼No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6521 Banbury Road 21239 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than College (1-4or 5+) 2 years Elementary/Secondary (0-12) Federal Government Data Processor injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked t any injury or other traumatic even once. Dr. Walter John Lammers Ella True Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (daughter) 3298 St. George's Court Hampstead, Maryland 21074 Ellen Kunert 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery 4 □ Donation 5 □ Other (Specify) 5-21-11 Pikesville, Maryland 21. Signature of Funeral Service Licensee Mitchell-Wiedereld Funeral Home, Inc. 6000 York Road Baltimore, Maryland 9. 23a. Part1. Erter the distase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a Atherosclerotic Cardiovascular Disease disease or condition resulting in death) years /Medical Due to (or as a consequence of): Examiner Hypertension Lee to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Vears Physician/Medical Examiner Type two Diabetes Mellitus the attending physician and ned for use as the burial-tran vears Division of Vital Records, P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 5 Other (specify) 9☐ Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ History of cerebrovascular accident or stroke of right occipitally e 1 Yes 2 No 3 Probably 4 Monknown Completed Chronic Kidney Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Dementia with Psychosis 1 ☐ Yes 2 ☐ No 1□ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ₽ No Other: 4 Unursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manney of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Matural 5 Pending after death.

Director: Ald in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral D Nurse Practitioner: 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Michelle C. Kalendek, Chup may 19, 2011 R097104 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michelle E. Kalende K, CRUP Genesis muchimedical Center 7700 York Rd. Towson, MB 21204

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 25 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dorothy Claire Finnerty 201 :00 P.M May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 530 Brownsville Road Queen Annes Centreville Social Security Number 8. Date of Birth
(Month, Day, Yea
Jan 8, Birthplace (State or Foreign Country) If Under 1 Year I If Under 24 Hrs 7. Age (In yrs. last birthday) Funeral 1 □ M 💥 🗓 F Min 73 Yrs. **Director** 217-34-4005 Jan. Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Tes 2 XXVo Maryland Centreville Queen Annes 10e. Street and Number 10g. Citizen of What Country? s 23a o, r must b Funeral United States of America 530 Brownsville Road 21617 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※XX No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō by 1 Never Married 2 Married 1 ☐ Yes X If Yes, Give Year or Dates. Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: "natural" Completed 3XXWidowed 4 ☐ Divorced Specify: White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) the event, th 12th Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) alth and Mental H 27 is marked of ir traumatic even မ Edgar T. Jordan Elizabeth Marie Swinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 2: any injury or other tonce. <u>Patricia D. Loforte (Daughter)</u> 530 Brownsville Road, Centreville, MD 21617 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Christ Evangelical 20c. Location - City or Town, State Date 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State May 26, Trenton, Maryland 4 Donation 5 Other (Specify) of Funifia Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Drive, Manchester, Maryland 21102 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest bck, or heart failure. List only one cause on each line. Approximate ediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death ed by the a detached f Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes 2 No 1 Tyes Division of Vital or Attending Physician: funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 2 200 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury s after death. 1 Yes 2 🗌 No completed filled in by the t Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) within 24 hours a To the Funeral I To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Modical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 only one) Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of (Month. Day. Year. 29d. Date signed

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 17, 2011 Peacola Walker Goodwyn 3:30 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bradford Oaks Clinton Prince George's 5. Social Security Number | If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth | Months | Days | Hours | Min. | Month, Day, Year) | Nov. 9, 1920 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖾 F Virginia 90 **Director** 226-60-0100 Yrs. Usual Residence of Decedent or 28a-f show 10a, State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 No MD Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a Funeral 7520 Surratts Road 20735 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give "natural", or þ 1 Never Married 2 Married Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: Black Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Domestic 8 Homemaker permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important; If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Johnny Walker Betty Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6101 Omar Ct., Upper Marlboro, MD Thelma Bradford (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Big Bethel Burial Park 1 X Burial 2 Cremation 3 Removal from State 4 Dogation □ Other (Specify) 25,2011 McKenney, VA 21. Signatu e of Fun a al Service Licen 22. Name and Address of Facility Johnson's Funeral Home 23872 11107 Doyle Boulevard, McKenny, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Priysician/ disease or condition YEAR Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events the burial-transit Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 month Month Year Day Pregnant at time of death ed by the a detached f 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ g Division of Vital Records, Completed 1 Tyes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s this certificate has performe 1 🗌 Yes 2 🗀 No rector, 25. Was case referred to medical Be 26. Place of Death (Check or#y one) examiner? Other: 2 1 🔲 Yes မ Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred after death. Director: After 1 Natural 2 Accident 5 Pending work 1 Tes 2 No Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

5 2

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** WILLIAM LEHMAN GUYTON, M.D. May 23 5:25P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BROADMEAD RETIREMENT COMMUNITY Cockeysville Baltimore County 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Sept 22, 1914 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1**∑**M 2□ F Maryland 186-36-3091 96 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Modical Examination to mainly 1 ☐ Yes 2 X No Director Maryland Baltimore County Cockeysville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 13801 York Road, 21030 USA Funeral death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No WWII If Yes, Give Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🎇 No Specify White 2 Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 College (1-4or 5+) 5+ Elementary/Secondary (0-12) Medical Surgeon 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fill and Mental h Be William Lehman Guyton, Sr. Carroll Elizabeth ဂ္ Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21204 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: if Item 27 is any Injury or other trauonce. William F. Blue, Esq. (P.R.)102 West Pennsylvania Avenue, #600, Towson, MD Date 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Green Mount Crematory 5/25/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MITCHECL WIEDEFELD FUNERAL HOME, INC. Martin D. Lawson 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine the burial-tran Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 □Yes 2 □ No. Ö 9 Unknown s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś Completed by 1 □ Yes 2 No 3 Probably 4 Unknown Record 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed The certificate 1 ☐Yes 2 ☐No Vital 1 ∐Yes 2 LetNo or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 17 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this ō 28a. Date of Injury (Month, Day, Year) funeral 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 I Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 3 ☐ Suicide determined 4 Homicide 29a. Certifie 1 🔽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8 30. Name and address of person who completed cause of death (item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

(1)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 11:18 AM Physician/ 2011 May Virgina H. Garrett Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical Center Anne Arundel Glen Burnie . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Min. 1 □ M 2 🗶 F (Month, Day Year)
1, 1926 Maryland 84 Director 214-22-1051 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Pasadena Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21122 807 224th Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Printing Company Statistician Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Unknown Frances John Esterka 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 807 224th Street Pasadena, MD 21122 Francine Meeks Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition May 27 cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Baltimore, MD 4 Donation 5 Other (Specify) Cedar Hill Cemetery 2011 21. Signature of Funeral Service Lipensee Name and Address of Facility
Stallings Funeral Home, P.A. 3111 Mountain Road Pasadena Maryland 21122201 ath. Do not enter the mode of dring, such a cardiac or respiratory arrest, 23a. Par 1. Enter the disease, or complications that shock, or heart failure. List only one cause on Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Dus to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last burial-transi attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No page 2 should be detached for 5 Other (specify) signed by Other significant conditions contributing to death but not resulting in the univerlying 23e. Did tobacco use contribute to the cause of death? ģ 4 Unknown 2 🗌 No 3 Probably 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? performed?

1 Yes 2 No Director: After this certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA ပ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 🔲 Yes 28d. Describe how injury occurred Certificate: injury Natural $5 \square$ Pending 2 🗌 No hours after death Accident Investigation 6 🗌 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide Could not be 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying, Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed only one and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatur

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Mo

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's S

11-03491 Helen Green Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

leien Green		1- For State Certificate of Death		201	1664
Physicia	_	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of De		3. Time of Death
Medical Exami		Helen Green	Month May 9, 2	Day Year 011	1340 hrs
			n, or Location of Death	4c. County of Death	
		81 Ocean Parkway Berlin		Worcester	
Funeral Director		216-18-4524 1 M 2XF 88 Yrs.	Days Hours Min.	Birth (MM/DD/YYYY) 9. Birth Foreign LO, 1923 Mass	
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
A		MD Worcester Berlin			1 Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number 10f. Zip Cod	de	10g. Citizen of What Coun	try?
th the M 23a nr 2			.811	USA	
hours after death with the Maryland "natural", or items 23s nr 28s-f sho Examiner must be notified at once.	Funeral		f Hispanic Origin? (Specify Yes or N uban, Mexican, Puerto Rican, etc.)	No- 14. Race - Americ White, etc.	can Indian, Black,
	P.	3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X		Specify: whi	
5-0036 led within 72 hours afte tlygiene. other than "natural", the Medical Examiner	g	during most of working	upation (Give kind of work done glife. DO NOT use retired)	16b. Kind of Business/Ir	ndustry
36 in 72 han dical	Completed	Elementary/Secondary (0-12) n College (1-4 or 5+) unk	1		
d with	팃	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle	Western Ele , Maiden Surname)	ectric
Z = = = 3 +	Be	Frank William Rafferty	Irene Gre	eato	
21 nould and Mei			Street and Number or Rural Route N	umber, City or Town, State,	Zip Code)
re, MD 212 s1 and 2 should b f Health and Ment if item 27 is marl er traumatic eve			ll Drive Wilmingt		
Baltimore, permit. Pages I as Department of Hee Impartment: If ite		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of crematory or other place)	f cemetery, Date	20c. Location - City or	rown, State
Liment thant:		4/X Donation 5 Other Specify,			
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Mc Impartment: If item 27 is ma	Į	2 Sir fur Euneral ecojce in 1986. Director State And Baltimore	dress of Facility atomy Board 655 W e, MD 21201	, Baltimore	Street
Physician		23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dy feiture. List only one cause on each line.		rrest, shock, or heart	Approximate Interval Between Onset and
Medical Examiner	1	Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular	Disease		Death
	-	or condition resulting in death) Due to (or as a consequence of):			
	5	Sequentially list conditions, if any liveding to immediate Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated			
uted nd ransit	Exa	events resulting in death) Last Due to (or as a consequence of): d.			
lox 68760, eath certificate be executed the strending physician and for use as the burial - transit	Medical	UNPENDED AMENDED			
3760, ficate be g physici s the buri	N N	IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death	3 Ectopic pregnancy	23d. Date of delivery Month D	ay Year
Box 687 death certific the attending p	Physician/	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	5Ectopic pregnancy	Wildian	ay roar
BO e deat the at ed for	hys	1 Yes 2 V No 9 Unknown 9 Unknown			
P.O.	P P	Part II. Other significant conditions contributing to death but not resulting in the underlying cau		tobacco use contribute to t	he cause of death? ably 4 Unknown
B, F	8	Cachexia			
cords, law requirements been so 2 should	plet				opsy findings available ompletion of cause of
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been sted in by the funeral director; page 2 should the	Completed		1 ✓ Yes	2 No 1 ✓ Ye	s 2 No
tal Recions: The location of t	Be	examiner?	Place of Death (Check only one)		
Physical direction	٤	1 Yes 2 No	THURSTING TIOTHE O	Residence 6 Other how injury occurred	Scene
n of \alpha oding Phy th. After the funeral	<u>Ë</u>	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c.	Yes 2 No	o now injury boodings	
isior Attencer death	icat	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory off	ice building, etc. 28f. Location	(Street and Number or Rus	al Route Number, City
Divis pital or At ours after d ieral Direct	Certification:	3 Suicide 6 Could not be determined (Specify)	or Town,	State)	
Hos Pun Fun		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the tim one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinions.			
To the within 7 To the complet	Medical	and manner stated.	cense number	29d. Date signed (Mor	
			.C.M.E.	May 10, 2011	
		30. Name and address of person who completed cause of death (Item 23a)			
		Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltim	ore Street, Baltimore, MD 2	21223	
St Regist	ate rar	31. Date filed (Mogth, Day, Year) AND 25 2011 32 Registrar's Signature And 25 2011			

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY Day 22 2011 Physician/ FRIEDA F GERSHEN 3:51 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death MANOR CARE SPRINGHOUSE PIKESVILLE BALTIMORE Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 X F Months Hours Min. (Month, Day, Year) 03/22/1913 Country) **Director** 98 MD 215-10-6637 Usual Residence of Decedent 28a-f show ms 23a or 28a-f shor must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD BALTIMORE PIKESVILLE 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 8911 REISTERSTOWN ROAD #103 21208 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, ir than "natural", or iter the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No WHITE Specify: Completed 3 X Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) DEPARTMENT STORE SALESPERSON other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mente Important: If item 27 is marked any injury or other transpores ည marked JOSEPH FRIEDMAN LEAH COHEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL GERSHEN/SON 2714 SUMMERSON ROAD, BALTIMORE, MD 21209 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place ARLINGTON CHIZUK AMUNO CEMETERY 20a. Method of Disposition 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 105/24/2011 BALTIMORE, MD 21, Sir, lature of Funeral Service Livensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) ALZHEIMERS DEMENTIA YEARS - Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) nding physician ause as the burial-Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🏋 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsv performed? death? certificate 1 Yes 2 No 2 💢 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) npleted filled in by the funeral 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred Funeral Director: After Hospital or Attending 24 hours after death. 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signatine and title of cert 29d. Date signed (Month, Day, Year) MAY 23, 2011 D0061199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009 JASON BLACK 6701 N.

MAY 25 2011

31. Date filed (Month, Day,

Box 68760

P.O.

Records,

Division of Vital

32. Registrar Signatu

CHARLES ST. SUITE 4105, TOWSON, MD 21204

DHMH 17 Rev 7/2009

State Registrar 22 South Greene Street, BALTIMORE, MID 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **May** Physician/ 2011 Houston 24 12:20A M Μ. Meetra Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Mandarin Hospice Harwood Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours 1 🗆 M 2 🔀 F 91 Director 246-12-4489 1-23-20 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Director Mitchellville Yes 2 No MD. P.G. 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number ō ms 23a or must be n Funeral U.S.A. 20721 11314 Dundee Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 0 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural" 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, the Me Elementary/Seconday (0-12) Unemployed 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Anna Perry George W. Harrison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11314 Dundee Dr. Mitchellville, Md. 20721 Gary Harrison/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1★ Burial 2 Cremation 3 Removal from State 6/6/11 Clinton, Md. 4 Donation 5 Other (Specify) Resurrection Cem. 2. Name and Address of Facility Hackett's Funeral Chapel, 21. Signa of Funeral Service License W. NOU NW 814 Upshur Street, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final 1yr. Physician/ Lymphoma disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Examine Due to (or as a consequence of): sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 XNo Month Day Year Pregnant at time of death 4 ☐ Pregnant a 9 ☐ Unknown Division of Vital Records, P.O. signed by the detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably XXUnknown Dementia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No 1 ☐ Yes 2🗶 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 1 🗌 Yes 2 **X**No 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: ieral Director: After filled in by the funer work? injury 5 Pending X Natural 2 🗌 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 29c. License number 25, 2011 D47603 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

MAY 25 2011

32. Registrar's S

William F. DuBoyce, M.D. 12158 Central Ave. Mitchellville, Md.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 24 ^D2011 9:30 A M MARY LEE HASKINS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 15 Acorn Circle Baltimore County Towson Social Security Number If Under 1 Year 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday If Under 24 Hrs 8 Date of Birth **Funeral** Days Hours Min 1 □ M 2 👿 F 90 Months 579-442735 ľ920 California Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland must be notified at 10d. Inside City Limits Director Maryland Baltimore County 1 Yes 2 No Towson 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 15 Acorn Circle, #302 21286 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor/Social Worker State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edwin H. Haskins Mary Lee Delaney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helene R. Haskins (Sister | P.R 15 Acorn Circle, #302, Towson, Maryland 21286 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) New Cathedral Cem. 15/28/ 2011 Baltimore, Maryland 21. Signatur ya mara Serva Libera Martin D. Lawson MITCHECL WIEDEFELD FUNERAL HOME, 6500 York Road, Baltimore. Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed inding physician and use as the burial-trans Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) the the Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part (23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has but director, page 2 sl autopsy performed 2 No 1 Tes Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 🗌 Yes ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred : After 1. Natural 5 Pending work 1 ☐ Yes 2 ☐ No Investigation within 24 hours after death

To the Funeral Director; A

completed filled in by the f Accident Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one 29b. Signatu and the of certif 29c License number 29d. Date signed (Month, D 206 49 2011

State Registrar

DHMH 17 Rev 7/2009

John Bowie, MD, 1734 York Road, Lutherville, Maryland 21093

32. Registrar's Sigr

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) **MAY 2.5 2011**

		•		extment of Health and N		
		_ State		artment of Health and N tificate of Death		L. 011 10010
		Registrar 1. Decedent's Name (First, Middle, Last)	Cer	uncate or Death	Reg 2. Date of Death	3. Time of Death
Physici Med	ical	Lena M. Hem	erich		Month 5/	17/11 4:45pm
Exami	ner	4a. Facility Name (if not institution, give street a. Joseph Richey		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A
Funera Director		5. Social Security Number 6. Sex 1 \square M 2	7. Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Pay, Ye 3 / 29	9. Birthplace (State or Foreign Country) MD
d dow	٦, [Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation		10d. Inside City Limits
Marylan 28a-f sk otified a	Director	MD N/A		Baltimore City		1 XXes 2 □ No
Maryland 21215-0036 Should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	Funeral D	10e. Street and Number 1403 Haubert St:	reet	10f. Zip Code 2123		g. Citizen of What Country? USA
eath tems er m	먑		s Decedent Ever in U.S. 13. V	Vas Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - American Indian,
036 s after o	ed by	1 Never Married 2 Married 1	Yes 2 X No	f Yes, specify Cuban, Mexican, Puerto Yes 2X No Specify:	nicari, etc.)	Black, White, etc. Specify: White
5-0	plet	15. Decedent's Education (Specify only highest grade com		lent's Usual Occupation kind of work done during most of work	ing 16	b. Kind of Business Industry
2121 within 73 giene. er than , the Me	Completed		lege (1-4 or 5+) life. DO	NOT use retired) ales Lady		Sales
and be filed be filed be filed be filed by ked other c event,	To Be	17. Father's Name (First, Middle, Last) Anton Zornak		18. Mother's Nam Magda	e (First, Middle, Maid lena H	den Surname) Hugel
Maryla 2 should be th and Men T is marke traumatic		19a. Informant's Name/Relationship (Type, Prin		g Address (Street and Number or Rura	al Route Number, Cit	ty or Town, State, Zip Code)
= 0 ± 0;		Gloria A. Dungar				altimore MD 21230
MOT Page 1 Dent of Int: If it		20a. Method of Disposition 1 ★ Mourial 2 □ Cremation 3 □ Remov 4 □ Donation 5 □ Other (Specify)	"" TT - 1 7	natory or other place)	101111 -	c. Location - City or Town, State Baltimore MD
Balti permit. Departin Importa any inju		4 ☐ Donation 5 ☐ Other (Specify) 21. Signal te of Funeral Service Licensee V :	ctor P. Doda22	Name and Address of Facility Charles L. Ste	vens Fun	eral Home, Inc.
		23a. Part 1. Enter the disease, or complication	s that caused the death. Do not en	r the mode of dying, such as cardiac	or respiratory arrest,	Approximate
Physician/		shock, or heart failure. List only one cause Immediate Cause (Final disease or condition	Demento	Ź .		Interval Between Qnset and Death
Medical Examiner		resulting in death)	e to (or is a consequente of:			
red nsit	Examiner	cause. Enter underlying Cause (Disease or linjury	Due to (or as a consequence of):			
be executed sician and burial-transit	cal Ex	that initiated events c c	Due to (or as a consequence of):			
760 cate b physic the b		d				
ivision of Vital Records, P.O. Box 68760 or Attending Physician: The law requires that the death certificate be explicated death. Director: After this certificate has been signed by the attending physician in by the funeral director, page 2 should be detached for use as the burial	Physician/Med	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
P.O. that the ned by t		Part II. Other significant conditions contribution	g to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of dea
ords, P.O. Be requires that the de been signed by the should be detached	ted by	AF & CATE				2 No 3 Probably 4 Unknown
Vital Records, sician: The law requires certificate has been signirector, page 2 should b	Completed by				24a. Was an autopsy performed	
in: Th lifficate or, pa	Be Co	25. Was case referred to medical		26. Place of Death (Check	1 Yes 2	No 1 Yes 2 No
Vita ysicia s cert direct	To B	examiner? 1 ☐ Yes 2 ☐ No Hospital	: 1 Inpatient 2 ER/Outpatien	Other:		e 6 Other (Specify)
on of Vital F ding Physician: 1 th. After this certifics funeral director, p		1 ☑ Natural 5 ☐ Pending	. Date of injury 28b. Time of (Month, Day, Year) injury	28c. Injury at work?	28d. Describe how i	110201177
Division of Vital al or Attending Physician. 's affer death. al Director: Affer this certific ed in by the funeral director.	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e.	Place of Injury - At home, farm, stre building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No leet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number,
Division (To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completed filled in by the fun	Medical C			ccured at the time, date and place, an	d due to the cause(s	s) and manner as stated.
o the Hi ithin 24 o the Fu	Med			igation, in my opinion, death occurred at eath occurred at the time, date and place 29c, License number	e, and due to the cau	lace, and due to the cause(s) and manner stated. use(s) and manner as stated. Date signed (Montal, Day, Year)
F 3 F 5		VIMM/MM	ne MD	D/30/2	2	5/18/11
6		30, Name and address of person who complete	d cause of death (Item 23a) (Type, P	MANNEST	Bitto.	MV 2/2/8
Sta Registr		31. Date filed (Month, Day, Year) MAY 2.5 2011	39. Registrar's Signature	Kel	- Olling	7 707

Lena Hemerich

1 - For State Registrar 1. Decedent's N **Physician** /Medical 4a. Facility Name **Examiner** Frankli 5. Social Securit **Funeral** Director 216-16-Usual Residenc permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I're Medical Examiner must be notified at once. 10a. State **Funeral Director** 10e. Street and 4116 V 11. Marital Statu 1 Never M Baltimore, Maryland 21215-0036 Be Completed by 3 Widowe Elementary/S HOrn 17. Father's Nar 2 19a. Informant's 20a. Method of 21. Signature of 23a. Part 1. Ent Immediate Caus **Physician** disease or concresulting in dea /Medical Examiner Sequentially list il any, leading to cause. Enter Ur Cause (Disease that initiated eve resulting in deat Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, IF FEMALE: 23b. Was deced Part II. Other sig Medical Certification: To Be Completed by 25. Was case re 27. Manner of D 1 Natural 2X Acciden 3 Suicide 4 Homicid 29a. Certifier 29b. Signature a

	Please	Type or Pri							•		-).	
For State Registrar		State of Ma	aryland .				ealth and Death	Mer		giene Reg. No	011	16	646
1. Decedent's Name ((First, Middle, La	ast)				_			Date of Dea	ath Day	y Ye:	ar	ne of Death
Ruth E	. Horn								5	18	20	116:	30 PM
4a. Facility Name (If n	not institution, gi	ve street and number)			4b. City,	Town, or	Location of Dear	ıth		4c.	County of D	eath	
Franklin 5. Social Security Num		Sex 7. Ag	e (In yrs. last	birthday)	If Under		ole If Under 24 Hrs Hours Min		Date of Birt (Month, Da	th		Birthplace (SI Country)	ate or Foreign
216-16-19:	25	1□M 2X)F	87	Yrs.	WOTHING	Duyo	Tiodis Willi	03	3/24/	1924		Maryla	nd
Usual Residence of Do 10a. State 1	Decedent 10b. County		10c. City, T	own or Loc	ation							10d Insid	te City Limits
MD	Baltir	nore		timore								1 🗆	Yes 2 X No
10e. Street and Numb	per				10f. Zip	Code				10g. Citi	izen of What	Country?	
4116 Walt	ter Ave	nue			2	1236					S.A.		
11. Marital Status		12. Was Decedent Armed Forces?		13. W	las Dece Yes, spe	dent of Hi cify Cuba	spanic Origin? (n, Mexican, Puer	Specify rto Rica	Yes or No in, etc.)	-	 Race - A Black, W 	merican India hite, etc.	n,
1 Never Married		1 □Yes 2 🔯 If Yes, Give	No	1	□Yes	2 X No	Specify:				Specify:	71- '	
3 ☐ Widowed 4		Year or Dates:									· · · · · · · · · · · · · · · · · · ·	White	
(Specify	5. Decedent's E y only highest gr	aucation ade completed)	1	6a. Decede		rk done a	luring most of wo	orking		16b. Ki	nd of Busine	ess/industry	
Elementary/Second	dary (0-12)	College (1-4or 5	+)) Operato	r		Gae	& E14	ectric	
17. Father's Name (Fig.	irst, Middle, Lasi	1)		TOM	Mac	TITIE	18. Mother's Na		rst, Middle.			CCLIC	
George Ho	oward A	mrein					Ruth E	Esth	er Ph	ipps	,		
19a. Informant's Nam						,	and Number or A						
Lester 1		(husband					Avenue		altim				21236
	Cremation 3 E	Removal from State	1	e of Dispos etery, crema				Date	.		·	or Town, Sta	
		^{fy)} Entombmen	t Bel										
21. Signature of Fune	eral Service Lice	nsee	,	22.	Name ar	nd Addres	ir Road	F.	Lass	ahn	Funera	al Home	e, P.A.
Immediate Cause (Fidisease or condition resulting in death) Sequentially list condition resulting in death) Sequentially list conditions to have cause. Enter Underly Cause (Disease or injust initiated events resulting in death) Las	litions, ediate ving jury	a. Interpolation of the control of t	a ocusequeri	es ofly.		le	A3	Pro	Like S	101 1302	1 -1 m	Orisot	and Death
T.=T.	_						_/ <i>Y</i>	-4	ν.	- 1			
IF FEMALE: 23b. Was decedent print the past 12 mo 1 □ Yes 2 □ N 9 □ Unknown	onths?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal de	eath 3 🗆	Ectopic p Other (sp		Shi	.?		7)	23d. Date of Month	delivery Day	Year
Part II. Other significa	ant conditions	contributing to death b	ut not resultin	ng in the und	derlying o	ause give	en in Part I.			obacco u Yes 2		e to the caus	e of death? 4 ☑ Unknown
					_			-		osy rmed?	prior deat	to completion h?	
25. Was case referred	d to medical						26. Place of De	eath (C	1 □Yes heck only o	2 No	1 10	Yes 2 □ No	
examiner? 1 ☑ Yes 2 ☐ No	0	Hospital:	ent 2∏FR	/Outpatient	3 □ □	Othe					6 ∏Other /	Specify)	
27. Manner of Death		28a. Date of Inju	ry 28	Bb. Time of		28c. Injury Work		_			y occurred	opouty)	
1 ☐ Natural 2X Accident	5 Pending investigation	n 5/11/20		Injury L M kmo l			? Yes 2 1 No		7	110			
	6 Could not be determined	e lan Plans of Ini	ury - At home c. (Specify)	e, farm, stre		y, office			City or To	wn, State	Number o	Rural Route	Number,
29a. Certifier (Check only one) 2	☑ CertifyIng P ☐ Medical Exa	hysician: To the best miner: On the basis o and manner st	of my knowle f examination	edge, death a and/or inv	occurred	at the tin	ne, date and place pinion, death occ	ce, and	due to the	cause(s	and manne place, and	er as stated. due to the ca	36 use(s)
29b. Signature and titl	le of certifier				290	c. License	number			29d. Da	te signed (M	lonth, Day, Ye	ar)
) \ \\.	1000	MI			Ì	D61.	777				1131		
30 Name and address	of pareon who	completed source of	ooth (lta Ca	30) /T		01.	<i>// </i>				101	\	
30. Name and address Kirmanj 31. Date filed (Month,	Ahmed	M D 32. Registr	· ·	Frank	lin	Sqı	are Dr	civo	e−Ba	ltin	ore,	MD	21237

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend Item 27 per dr., g915,05/25/2011dhb

Certificate of Death

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year era a Id Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death **Examiner** 4b. City 4c. County of Death Baltimore Harbor Hospita If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 - M 2 F Months 0ays Min. Aug 12, West Virginia Director 234-32-8617 83 Yrs Usual Residence of Decedent items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medio-I Examiner must be notified at 10d. Inside City Limits Director Md. Baltimore 4 8 1 1 Pyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 408 Frankle Street 21225 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. If Yes, Give Year or Dates 3 ₩ Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Soda/Carbonation Co. 12 Dispatcher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Helmick George Ramage Grace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Hall, daughter 911 Sidehill Dr. Bel Air, Md. 21015 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/17/11 Elkridge, Maryland Meadowridge Memorial 22. Name and Address of Facility Gonce Funeral Service P.A. 21. Signature of Funeral Service Licenses 4001 Ritchie Hgwy. Balto. Md. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. shock, or heart failure Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition oronary Medical resulting in death) Examiner LIMBROWN Sequentially list conditions, Examiner cause. Enter Underlying spital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Know w -insom attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year signed by the and be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown cate has been signification categories, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 2 No Yes 1 Tes funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: ဂ္ဂ 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After X Natural 5 \square Pending work 1 Yes 2 No Investigation Accident Suicide Sould not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Notes Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5. Hanover 3001 Baltimore seorge

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year) MAY 2 5 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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100. State 100. Coomy 100. State 100. State 100. Coomy 100. State 100								24 Hrs. 8. Date of (Month) 1 1 -	f Birth n, Day, Year 22-19	9. Birth Cou PEN	nplace (State or Foreign Intry) NSYLVANIA		
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Provided to the position of)36 irs after death	al", or items 2. xaπiner mus	þ	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 Xes 2 No			gin? (Specify Yes on the Puerto Rican, etc.)	or No- .)	Black, White	e, etc.		
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Physician Medical Examiner Part Continue Continu	Bal permit Depar	any in		21. Signature Funeral Service Lice	ee						21237		
FEMALE 236. Was decedent pregnant in the past 12 months? 1 1 1 1 1 1 1 1 1	/ /Mc Exa	edical miner				disease or condition resulting in death) Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Type Das to (or as a consequence)	истює сту:	4 9 42	ZHEII	7 <i>E</i> K	25	Years.
Coronary Application Continuence Coronary Application Coronary	. Box 6	D g	ysician/Medic	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	I death 3							
25. Was case referred to medical examiner? 1 Ves 2 No 26. Place of Death (Check only one) 27. Manner of Death Nursing Home 5 Residence 6 Other (Specify) 28. Date of Injury M 1 Ves 2 No 28. Date of Injury M 1 Ves 2 No 28. Date of Injury M 1 Ves 2 No 28. Describe how injury occurred 28. Describe how injury occurred Number or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, one) 28. Describe how injury occurred Number or Rural Route Number, or Rur	ds, P.	be be	þ	•				I. 23e.			4		
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of Ortifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 44. CHILADI, M.D. 7600 OSLER Dr. Towson MD 21204	On O	After		1 Natural 5 Pending	(Month, Day Year)			_	cribe how in	njury occurred			
29a. Certifier (Check only one) 29a. Signature and title of Gritish 29b. Signature and didress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Towsow MD 21204	Division of the nation of the deat	l Director	ertifica	3 Suicide 6 Could not	be 28e. Place of injury - At ho	ome, farm, s	treet, factory, office				ural Route Number,		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A.H. GHILADI, M.D. 7600 OSLER Dr. Towson MD 21204	Hospite 24 hours	Funera stely fille		(Check only 2 Medical Exa	aminer: On the basis of examina	wledge, dea ation and/or i	th occurred at the time, date a nvestigation, in my opinion, de	and place, and due eath occurred at the	to the cause time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A.H. GHILADI, M.D. 7600 OSLER Dr. Towson MD 21204	To the	To the	Me	29b. Signature and title of Cartillar	31/11			49					
31. Date filed (Month, Day, Year) 32. Registrary, Signature				30. Name and address of person who	completed cause of death (Iten	n 23a) (Type							
		C+	ate.	A.H. GHILAD 31. Date filed (Month Day, Year) MAY 25 2011			USLERD	r. 10W	DON	110	41604		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 29d per dr., g915,05/25/2011dhb

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, hast) 2. Date of Death 3. Time of Death Physician/ Month-ARVEY Year 201/ ACKSUN 20 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Tate Hospice House Linthicum Anne Arundel 5. Social Security Number 6. Sex 7, Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Country)UNK **Funeral** 1 M 2 🗆 F Days Hours Min. April 16, Director 212-34-5050 74 1937 Usual Residence of Decedent shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Annapolis 1 🗆 Yes 2 💆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Completed by Funeral 131 Jennifer Road 21401 11. Marital Status unk 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Bace - American Indian. Armed Forces? unk If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. "natural", or i 1 Never Married 2 Married 1 Yes 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation Uni (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry unk (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 817 S. Campmeade Rd; Linthicum, MD 21090 Tate Hospice House 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 🖾 Other (Specify) in state 21. Sign fre of Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Balto, MD 21201 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. 23a. Part 1. Approximate Interval Between Immediate Cause Final Onset and Death ORUPHARYN Physician/ disease or condition resulting in death) / Medical Due to (as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of attending physician and for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Other (specify) Yes 2 ☐ No io tne Funeral Director; After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1/Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) USPICE (+04) Hospital Other: 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work ≀ 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director; 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) the within To the 29b. Signature and title of certifie ٥ 29c. License number 29d. Date signed (Month, Dav. Year) / 4 2011 W Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL ENTA W 445 Julal NSE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 25

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Barbara Ann Jessup May 21, Physician/ ¹²7011 8:22P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death
Baltimore Towson Gilchrist Hospice 7. Age (In yrs. last birthday) 53 yrs. Birthplace (State or Foreign Country)
 MD Social Security Number If Under 24 Hrs. **Funeral** If Under 1 Year 8. Date of Birth 217-68-0097 1 □ M 2🔀 F 0*6\12*1\11957 **Director** Usual Residence of Decedent show 10a, State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Directo must be notified Baltimore MD 28a-f 1 X Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 21206 0 10e. Street and Number Page 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. Fant: If item 27 is marked other than "natural", or items 23a jury or other traumatic event, the Medical Examiner must b. Funeral 3926 Marx Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. 3 Widowed 4 Divorced SpeciBlack Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hospital Supervisor Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname Annie Mae Davis James H. Adams 임 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9 Debkay Court, Essex, MD21221 Betty J. Adams / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey crem 20c. Location - City or Town, State Department of I Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 5/23/2011 Woodbine, MD 4 Donation 5 Other (Specify) Maryland Cremation Services PO Box 1413, Baltimore, MD Signature of Funeral Service Licensee Dorota Marshall 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final Ph, sician/ Dreast cancer disease or condition resulting in death) Motostatic Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year Other (specify) Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 200 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence Hospital: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury Natural 5 Pendina 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. onlyrone 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 BM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Yea NAY 25 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

William Knecht		State of Maryi - For State Registrar		tificate of L		id Meritari		g. No. 201	16651	
Physician Medical Examine	1		iam Knec	ht III ECHT	-		2. Date of Death Month May 21, 20	Day Year	3. Time of Death 2103 hrs	
	ı	4a. Facility Name (if not institution, give street and no 1400 Blk. Telegraph Road	imber)		City, Town, o	r Location of Deat		4c. County of Death Cecil	h	
Funeral Director		5. Social Security Number 6. Sex 12. M 2. F	7. Age (In yrs. la	ast birthday) 2 Yrs.	If Under 1 Ye Months Da			1958 Co		
d how any		Jsual Residence of Decedent 10a. State 10b. County MD CECIL	10c. City,	Town or Location	RISING	G SUN			10d. Inside City Limits 1 Yes 2 No	
the Maryland a or 28a-f show tified at once.		10e. Street and Number 19 SOUTH VIEW ROAD	<u> </u>		10f. Zip Code 2	1911	10	g. Citizen of What Cou	ntry?	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	⋧┞	11. Marital Status 1 Never Married 2 Married 1 Yes 3 Widowed 4 Divorced If Yes, Give Yei or Dates: 15. Decedent's Education (Specify only highest gra	2 X No	If Yes 1 Y 16a. Decedent's				White, etc.	ican Indian, Black, HITE Industry	
5-0036 led within 72 hours sygiene. other than "natu	and in	Elementary/Secondary (0-12) College (1 1 2	I-4 or 5+)	_		e. DO NOT use re	IAN		EARCH	
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than umarite event, the Medical		17. Father's Name (First, Middle, Last) WILLIAM [9a. Informant's Name/Relationship (Type, Print)	KN	ECHT,		JANE			GROTHAUS)	
re, MD 2 shou s l and 2 shou f Health and l fitem 27 is left traumatie	-	SUSAN J. DONALDSON/S 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal fr	20b. F		WALMSI	LEY DRI	VE WI	LMINGTON 20c. Location - City or	, DE 19808 Town, State	
Baltimore, permit. Pages I an Department of He important: If ite injury or other tr		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	CE		ne and Addres		-26-11 VACH/RO VE RO	WILMINGS SEDALE FU SEDALE, N	JNERAL HOM	
Physician Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):								
de la	Yallille	cause. Enter Underlying Cause	a consequence of							
be executed sician and aurial - trans	- 12 -	d. UNPENDED X AMENDED	#5 Per I	7H G917	5-1-11 7/01/20	vt)11 JH		V. 1841-06.72		
68 certif nding	y Sicial V	nast 12 months?	nant at time of de	2 Fetal	death 3 r (Specify)	Ectopic pregr	nancy	23d. Date of deliver Month	y Day Year	
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Functal Director: After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for undireal Certification: To Be Completed by Diversity	3	Part II. Other significant conditions contributing t	o death but not re	esulting in the und	derlying cause	given in Part I.		pacco use contribute to 2 ✓ No 3 Pro 24b. Were a	-	
tal Records, tian: The law require certificate has been signed to spector, page 2 should be Completed		25. Was case referred to medical			26 Plac	ce of Death (Check	autops perform 1 Yes 2	med? death?	completion of cause of es 2 No	
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that th within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach indical Contributed by D		examiner? 1 Yes 2 No Hospitai: 1 27. Manner of Death 28a. Date		ER/Outpatient 28b. Time of Inju	3 DOA	Other Nurs	ing Home 5 1	Residence 6 Other Owner Own		
Division o spital or Attending sours after death. neral Director: After filled in by the fune	וווייים	2 Accident Investigation 3 Suicide 6 Could not be	2011	2100 hrs ome, farm, street,		Yes 2 No building, etc.	28f. Location (S or Town, St	treet and Number or Re	ural Route Number, City	
To the Hospital within 24 hours a To the Funeral completely filled		29a. Certifier 1 Certifying Physician: To the be (Check only one) 2 Medical Examiner: On the basis and manner:	st of my knowledo of examination a	ge, death occurre	n, in my opinio	on, death occurred		and place, and due to the	he cause(s)	
		29b. Signature and title of certifier				.M.E.		29d. Date signed <i>(Mo</i>	onth, Day, Year)	
(30)		30. Name and address of person who completed cau Ana Rubio MD. Assistant Medical	Examiner 9	900 W. Baltim	ore Street	, Baltimore, N	1D 21223			
Stat Registra	e	31. Date (1) 4 (40/2, 59/2011 32. R	egistrar's Signatu	harles					-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Elizabeth A Ki	SS	Registrar	state of Maryla	and / Dep Ce	partment of e <i>rtificate o</i> a	f Health ai f Death	nd Mental		201	1665
Physical Exar	cian nine	1. Decedent's Name (First, Mid Elizabeth 4a. Facility Name (if not institut	,,	iss				2. Date of Dea Month May 17, 2	eg. No. Ith Day Year	3. Time of Death 1555 hrs
		96 Weldon Road	ion, give street and nu	mber)		4b. City, Town, o Curtis Bay		eath	4c. County of Dea Anne Arunde	
Funera Directo		5. Social Security Number 214-92-3866 Usual Residence of Decedent	6. Sex	7. Age (In yrs.	. last birthday) 33 Yrs	If Under 1 Ye		Min. I	C	rthplace (State or Foreign ountry) Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other tranumatic event, the Medical Examiner must be notified at once	Funera	10a. State 10b. County Maryland Anne 10e. Street and Number 96 Weldon Re 11. Marital Status 1 Never Married 2 XM 3 Widowed 4 Di	Dad 12. Was Deciderried Armed Foundament Fo	edent Ever in Urces?	If Your 1 16a. Decedent	10f. Zip Code 21.2 s Decedent of Hi es, specify Cuba Yes 2 X No	spanic Origin? n, Mexican, Pue specify:	(Specify Yes or No	0g. Citizen of What Cou USA 14. Race - Amer White, etc. Specify: Wh.	ican Indian, Black, ite
MD 21215-0036 d 2 should be filed within 72 hours after the and Mental Hygiene. n 27 is marked other than "natural", wmatic event, the Medical Examiner.	o Be Completed		, Last) Kiss	4 or 5+)	Homer	naker	18.Mother's Na	me (First, Middle, Man Sa:	Househol Maiden Surname) slinas	.d
Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and Nimportant: If item 27 is injury or other traumatic	º	Susan Delozie 20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other S	er - sister	20b.	19b. Mailing 6001 Place of Disposit crematory or other	Buffalo ion (Name of ce er place)	Road,	Mt. Airy	ber, City or Town, State , MD 21771 20c. Location - City or	Town, State
Balti permit. Departu Import		21. Signature of Funeral Service.	License	0	22. Na	ame and Address	of Facility St	allings H	ll Crownsv Funeral Hom dena, MD 21	e, PA
Physician /Medial Examiner	00.0	23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)		nd mixed	l (Carispro	mode of dying,	such as cardia	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
60, the executed the executed by brician and extensit	ledical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c Due to (or as a c d.	onsequence of	ń.	r me,g9	16 6-6-	11 sm		
). Box 6876 the death certificate by the attending phy-	2	IF FEMALE: 23b. Was decedent pregnant in th past 12 months? 1 Yes 2 No 9 ✓ Unk Part II. Other significant conditi	4 Pregnan	h it at time of dean	2 Feta ath 5 Othe	death 3 [Ectopic preg			ay Year
cords, P.O. I law requires that the has been signed by the standard of the sta	Completed by		ons contributing to d	eath but not re	esulting in the und	derlying cause g	iven in Part I.	1 Yes 24a. Was an autopsy	prior to co	
Vital Reco	To Be Cor	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpa	atient 2	ER/Outpatient (26.Place	of Death (Check		ed? death?	2 No
Division o spiral or Attending tours after death. reral Director: After	ertification:	3 Suicide 6 X Could 4 Homicide	not be IG 5-	17-11	28b. Time of Injuft of 15:41 me, farm, street,	0 1 Y	at Work?	28d. Describe how Unknown 28f. Location (Str.	w injury occurred eet and Number or Rure tel 96 Weldon	al Route Number City
To the How within 24 h To the Fur	edice	29a. Certifier (Check only one) 2 Medical Exam 29b. Signature and title of certifier	rsician: To the best of iner: On the basis of e and manner state	xammation an	e, death occurred ad/or investigation	, in my opinion,	death occurred	d due to the cause(at the time, date an	s) and manner as stated d place, and due to the	cause(s)
		Covole 30. Name and address of person w	HOLO completed cause of	200 V	23a)	29c. License O.C.M		1.	29d. Date signed (Mont May 18, 2011	h, Day, Year)
Sta			stant Medical Ex		00 W. Baltim	ore Street, E	Baltimore, M	ID 21223		
Regist	ar	MAY 2 0 2011	anna	1. 6	ale					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 2011 4:15 PM^M Kathleen M. Klemm May 11, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 723 Murdock Road Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 😾 F 563-68-1596 64 Dec 16, 1946 Director Illinois Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expriner in 1st by notified at once. 1 ☐ Yes 2 ☐ No Director Baltimore Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 723 Murdock Road 21212 USA Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify white þ Specify: 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) 1 2 nurse healthcare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Gregory Kemblowski Lorraine Marie-Therese Weir ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John Klemm/spouse 723 Murdock Road Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 □ Other (Specify) Signature of Funeral Serv Ronal d S. Wade ^{22.} State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore, MD 23a. Pirt1. Enter the dispase, if complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia e Cause (Final Melastatic Lun Cancinoma Physician ne year disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ZNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 X No 1 □ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 🔀 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

P.O. I Division of Vital Records, ieral Director: A within 24 hours a

Baltimore, Maryland 21215-0036

Box 68760,

State Registrar

Medical

29a. Certifier

DHMH 17 Rev 1/2001

and manner stated.

32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print),

H.Levine

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

ause of death (Item 23a) (Type, Print),
6569 Worth Charles St. Suite 201

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Keller ODETT 20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center Baltimore 8. Date of Birth (Month, Day, Year) August 18, 1958 6. Sex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 🕅 M 2 🗆 F 220-68-2245 52 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f show Director Baltimore Dundalk Maryland 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygione. Important: If Item 27 is marked other than "natural", or Items 23a or 2 any Injury or other traumatic event, the Medical Examiner must be no once. 7803 St. Fabian Lane 21222 Funeral Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 🗌 Yes 2 💢 No Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 years Home Improvement Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Warren Tucker Nancy Schmidt ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnn Keller 7803 St. Fabian Lane, Dundalk, Maryland wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 24, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland □ Donation 2011 Signature of Fu ^{22, Name and Address of Facility}
Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, MD. erat Service Licenses Bur 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the complex or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** /Medical Examiner theroscle ros1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burtal-transit Box 68760 resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 2 🗌 No Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Tyes Completed 24a. Was an autopsy performed 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 2 PER/Outpatient 3 DOA 1 Inpatient မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1

Matural Injury 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 29a. Certifier 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

> 23d. Date of delivery Day 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 2 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 □ No 1 TYes 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) May 20,201 4940 Eastern Avenue, Baltimore, MD, 21224

Year

2011

USA

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 X No

Kentucky

State

Registrar

31. Date filed (Month, Day, Year) 25 2011

(SURGIO

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G4 LEUO

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 CHARLES THOMAS LOWRY May 12:50 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick Inder 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1X M 2 □ F Months Days Hours West Virginia Feb. 18. Director 285-36-7883 72 Usual Residence of Decedent 28a-f show 10a. State Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Frederick Frederick 10e. Street and Numbe 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 21704 USA 9402 Brigadoon Way items ; 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, med Forces?
Yes 2 \(\square\) No Black, White, etc. þ "natural", or 1 Never Married 2 X Married 1 X Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify:White 3 Divorced 4 Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than ' life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Self-Employed Flooring Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Esther I. Minter Conrad C. Lowry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is 9402 Brigadoon Way, Frederick, MD Marty C. Keeran Lowry-Wife injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory of Skaggs-McVey 1 X Burial 2 Cremation 3 Removal from State 5-22-11 Victor, WV 4 ☐ Donation 5 ☐ Other (Specify) Wallace and Wallace Funeral Home 22. Name and Address of Facility any in Holley & Church Sts., PO Box 335, Ansted, WV 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that initiated events burial-tran resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) detached for in the past 12 months? Dav Year Pregnant at time of death Yes 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð sign, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy
performed?

Yes 2 No this certificate 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical upleted filled in by the funeral director Be 26. Place of Death (Check only one) examiner? Hospital 2 🗹 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at After 28d. Describe how injury occurred 1 Matural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation safter death 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Funeral I

within 2 To the I

State Registrar

Medical

29a. Certifier

(Check

29b. Signature and title of certifier

Sathyabama

5

31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Naidu

w

400

1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

MDD 71068

Frederick,

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are L State of Maryland / Department of Health and Mental Hygiene	egible 2011	16656
Certificate of Death	Rea. No.	

	1- For State Registrar Glate of Maryland / Department Certificate		-	1 10001
Physician Medical Examine	John Lewandowski		Reg. No. 2. Date of Death Month Day Yea May 14, 2011	3. Time of Death
	4a. Facility Name (if not institution, give street and number) 3914 Brooklyn Avenue	4b. City, Town, or Location of Deat Baltimore		
Funeral Director		If Under 1 Year If Under 24Hr Months Days Hours Min		Birthplace (State or Foreign Country) MD
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ation		10d. Inside City Limits
faryland	MD Anne Arundel Glen	Burnie		1 Yes 2XXNo
th the Marylanc 23a or 28a-f sh notified at once Il Director	1	10f. Zip Code 21 0 6 0	10g. Citizen of Wha	·
er death with , or items 23 r must be no		/as Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.) 14. Race - White,	
ours aft	or Dates:	Yes 2 No specify: ent's Usual Occupation (Give kind of v	Specify:	White
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked offer than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Elementary/Secondary (0-12) College (1-4 or 5+) during r	most of working life. DO NOT use reti Construction Wo	red)	truction
1215- I be filed antal Hyg rrked oth vent, the	Gilbert R. Ebling, Sr.	18.Mother's Name	(First, Middle, Maiden Surname)	
MD 21215-0036 At 2 should be filed within 7 th and Mental Hygene, a 27 is marked other than sumatic event, the Medica. To Be Comple	19a. Informant's Name/Relationship (Type, Print) Bonnie K. Ebling / Sister 123	ng Address (Street and Number or F 5 Haubert St,	Rural Route Number, City or Town, Baltimore MD	State, Zip Code) 21230
Ore, ges l an of Hea If iten	20a. Method of Disposition 1 Burial 2 Cremation 3 X Removal from State Ardent	sition (Name of cemetery,	Date 20c. Location - C	ity or Town, State
Baltimore, permit. Pages 1 an Department of Hea Important: If ite Injury or other tra	Other Specify:	Name and Address of Facility	20/2011 Hanov	ver MD
M 립러크를 Physician	Ch	arles L. Steve	ens Funeral Ho Avenue, Baltin	ome, Inc.
/Medical	failure. List only one cause on each line. Immediate Cause (Final disease a. Methadone Intoxicati	the mode of dying, such as cardiac or	respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death
	Due to (or as a consequence of): Sequentially list conditions. b			
ted Insit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated c.			
and transit	events resulting in death) Last Due to (or as a consequence of): d.			
760, cate be exect physician an he burial - tr	■ MENDED 23a,27,28a-f,pe IF FEMALE: 123c If yes outcome of a second of the seco	er me,g915 6-3-11	sm	
D. Box 68760, the death certificate be executed by the attending physician and ashed for use as the burial - transit Physician/Medical Ex	23b. Was decedent pregnant in the past 12 months?	tal death 3 Ectopic pregnan	23d. Date of de Month	livery Day Year
that deta	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco use contribut	
Records, The law require ficate has been si, page 2 should b.			1 Yes 2 No 3 24a. Was an 24b. Wer	Probably 4 Unknown e autopsy findings available
	25. Was case referred to medical		autopsy prior deat	to completion of cause of
Vital hysician this cert	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	26.Place of Death (Check on 3 DOA Other Nursing		Who == 0 == ==
on of adding Pt. th. After a funeral ion: T	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of In	jury 28c. Injury at Work? 2	8d. Describe how injury occurred	orier: Scene
Division ospital or Attendia hours after death hours all Director: A y filled in by the far Certification	2 Accident Investigation fd 5-14-11 fd 12:2 3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street		nknown Bf. Location (Street and Number of	Pural Pouto Number City
Die Hospital 24 hours e Funcral letely filled	4 Homicide determined (Specify) Residence	В	altimore, Md.	ooklyn Ave.
To the within To the complete	Certifying Physician: To the best of my knowledge, death occurred to the basis of examination and/or investigation and manner stated.	ed at the time, date and place, and du on, in my opinion, death occurred at the	ue to the cause(s) and manner as a ne time, date and place, and due to	stated. o the cause(s)
\$ 2	29b, Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year)
W	Name and address of person who completed cause of death (Item 23a)		May 15, 2011	
Y∪ State ³	Margarita Korell MD. Assistant Medical Examiner 900 W. 11. Date filed (Month, Day Year) 32. Registrar's Signature	Baltimore Street, Baltimore,	MD 21223	
Registrar	Date filed (Month, Day Year) NAY 2 5 2011 32. Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ROBERT C. LAUMAN MAY 2011 10.20P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MANOR CARE-ROSSVILLE ROSSVILLE BALTIMORE **Funeral** Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign XX M 2 D F Months Days Hours Sept. 12 Year) 1923 Maryland Director Yrs 216-16-3500 Usual Residence of Decedent "natural", or items 23a or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland event, the Medical Examiner must be notified at Director Baltimore County Marvland Baltimore 1 Yes X X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3302 Garnet Rd. 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces? ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White XX Widowed 4 ☐ Divorced If Yes, Give Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) <u>Carpenter</u> State of Marvland 1 and 2 should be filed w of Health and Mental Hygi item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Carl Lauman Elizabeth Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phillip R. Lauman (Son) 3328 Woodside Ave. Baltimore, Md. 21234 item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place) XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) of Faith 5-26-2011 Baltimore, Md Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7401 Belair Rd. Lassahn Funeral Home J asoula Baltimore, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory Approximate Interva! Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Leu Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

December at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year signed by the a 9 Unknown a Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should peen 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? page 2 s performed' his certificate h Yes 2 1 🗌 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospita Other: 2 4 10 မှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No Il Director: A ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D

completed filled i Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certif 69540 M-D 2011. MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jigan Walker ४४१ ३

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Physician/ 7:00 PMM 19 2011 John J. Miara Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 255 Magothy Bridge Road Pasadena If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, If Under 1 Year Social Security Number 6. Sex **Funeral** Year) (Month, Day, Yea
June 24, Days Hours Min. 1 🔀 M 2 🗆 F Director 77 Yrs 1933 Pennsylvania 219-28-1793 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location Director 1 Yes 2 No Pasadena Maryland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral USA 21122 <u>255 Magothy Bridge Road</u> Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 Never Married 2 Married Completed by 1 X√es 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City School Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other tha School Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Trzcinski Elizabeth John Miara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 46 Nicholson Drive Pasadena, MD 21122 Mark Miara Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Page 1 a
Department of IImportant: If ite
any injury or ot
once. cemetery, crematory or other place) May 24 1 📭 Burial 2 🗆 Cremation 3 🗆 Removal from State Glen Burnie, MD 4 Donation 5 Other (Specify) Haven Cemetery 2011 21. Signature of Funeral Service Lio 22. Name and Address of Facility Stallings Funeral Home, P.A. Poad Pasadena Mountain 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final ard or Physician/ disease or condition resulting in death) Medical Due to (o Examiner CO10 nari Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) To the Funeral Director: After this certifica e has keen signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical **Records, P.O. Box 68760** IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 2 🗌 No 1 Tes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

Division of Vital 24 hours after death Funeral Director: within 2 To the I

10

DHMH 17 Rev 7/2009

State

Medical

29a. Certifier (Check

only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Bassim Badro 7845 Oak Wood Rd.

5

Registrar

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

20

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Glen Burnie, MD 21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death L Decedent's Name (First_Middle, Last) 2. Date of Death Month Physician/ Richard Malcolm Marcroft mAY 2011 1325P Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE ST JOSEPH MEDICAL CENTER TOWSON If Under 8. Date of Birth g. Birthplace (State or Foreign If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours (Month, Day, Year) 04/29/1931 1 **X** M 2 □ F Months Yrs Pennsylvania **Director** 80 215-32-7341 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director Examiner must be notified 1 Yes 2 X No Kingsville MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral 23a U.S.A. 21087 2609 Reckord Road items . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Marital Status Black, White, etc. P ò 1 Never Married 2 X Married 2 **X** No 1 Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. White Specify: 27 is marked other than "natural", traumatic event, the Medical Exa Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Maryland State Elementary/Seconday (0-12) College (1-4 or 5+) Civil Engineer Highway Administration 2 should be filed with h and Mental Hygien 7 is marked other tl 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Evelyn Buck Harold C. Marcroft 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health i 2833 Willow Street Pike N. - Willow Street, PA 17584 Andrew D. Marcroft 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 9 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. Memorial Gdns: 05/26/2011 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Betweer Onset and Death Immediate Cause (Final Ph_sician/ CONGESTIVE HEART FAILURE disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** SEVERE ISCHEMIC CARDIOMYOPATHY Seque tially list non-litions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami <u>CORONARY ARTERY DISEASE</u> ending physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Year the 8 g Unknown g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 2 No Other: 1 🗌 Yes ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗶 Inpatient 2 🗌 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No injury 1 X Natural 5 Pending s after death. Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide filled in by determined City or Town, State) 24 hours a Funeral L Medical 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and glue to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 29b. Signature and tit 29c. License number 29d. Date signed (Month, Day, Year) D24034 my 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON, MARYLAND 21204 TIMOTHY LOW, M.D 7601 OSLER DRIVE

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** 2011 Gwendolyn Moore /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Itimore 105pita-L If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 😿 F 65 214-50-1845 Director Dec 18, 1945 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show at 1√∑Yes 2 □ No MD must be notified Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō 23a 501 W. Franklin Street 21201 USA Funeral items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ black 3 TWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation unk (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Monee. 12 clerical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Doris Gardner Alphonso Tillman 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4559 Shamrock Avenue Baltimore, MD Maria Tillman/sister in law 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4□Donation 5 X Other (Specify) in state 21. Signature of Euneral Service Licensee State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part L. Enter the disease or condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate use (Final disease or condition resulting in death) 20 Physician Hewit /Medical Due to (or as a consequence of): Examiner my occordie 20 Sequentially list conditions Due to lo as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9☐Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? 3 1 Tes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an certificate has b irector, page 2 sl autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) dire 1 ☐ Yes 2 💢 No 2 XER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27, Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No hours after death. Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours arre To the Funeral Div Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

toward

827

32. Registrar's agnatur

407

29c. License number

29d. Date signed (Month, Day, Year)

5-14-11

Pt known as: Knot Michelman

			State of Maryland / Department / Department / Department / Department / Department / Department		-	
			1 - State Registrar Cer	rtificate of Death	Reg.	N2011 16661
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Kurt Michelman		May 2	
1	Examir	ner	4a. Facility Name (If not institution, give street and number) 5:	4b. City, Town, or Location of Death		4c. County of Death
	Funeral Director		5. Social Security Number 389-18-7392 6. Sex 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yes 04/19/19	
	ne Maryland 8a-f show diffied at	ector	MD 10b. County 10c. City, Town or Lo	Pikesvi	lle	10d. Inside City Limits X☐ Yes 2 ☐ No
	ath with the s 23a or 2	Funeral Director	326 Chalk Hill Drive	10f. Zip Code 21 208		Citizen of What Country? USA
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Inductant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventre must be rediffed at once.	þ	1 ∐ Never Married 2 🔀 Married 1 🖼 es 2 🗍 No	Nas Decedent of Hispanic Origin? (Spe if Yes, specify Cuban, Mexican, Puerto I I □Yes 2 ☑No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
1215-	vithin 72 h ane. than "natu	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give life. I	dent's Usual Occupation kind of work done during most of working NOT use retired) Interior Desig	ng	Kind of Business/Industry Service
Maryland 21215-0036	uld be filed v Aental Hygi rked other tic event, tr	To Be Co	12 3 17. Father's Name (First, Middle, Last) Boris Michelman	(First, Middle, Maid gelina		
, Mary	and 2 shouealth and Market is many in 27 is mane in traumane.		19a Informant's Name/Relationship Type. Print) Wife 326	ng Address (Street and Number or Rura Chalk Hill Dri	Ne, Pike	y or Town State, Zip Code) SVIIIe, MD
Baltimore,	Pages 1 tment of H tant: If iter jury or oth		4□Donation 5□Other (Specify) Final Jou	rney Crem. 5/26	5/2011 W	Location - City or Town, State Joodbine, MD
Bal	Departition Depart		21. Signature of Funeral Service Licensee Dorota Marshall 22 23a. Part 1. Enter the disease, or complications that caused the death. Do not ent	Name and Address of Facility Maryland Crem PO Box 1413,	ation Se Baltimo	ervices re, MD 21203
760,	Physician /Medical /Medical is partial-transit per partial-transit	cal Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter or denying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			Approximate Interval Between Onset and Death
.O. Box 68	The law requires mat the death certificate ate has been signed by the attending physoage 2 should be detached for use as the	Physician/Medi		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ords, P.	w requires that been signed b should be deta	ğ	Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I.		o use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☐ Únknown
		e Completed	25. Was case referred to medical		24a. Was an autopsy performed 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
¥ <	dis ys	To Be	exampler? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	26. Place of Death t 3 DOA Other: 4 Nursing Hor		6 ☐ Other (Specify)
	or Attending after death. Director: After in by the funer	Certification: 1	27. Many of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 5 Pending investigation 4 Secretary (Month, Day, Year) 28b. Time of Injury (Month, Day, Year) 28b. Time of Injury (Month, Day, Year) 28b. Time of Injury 38b. Time of Injury 28b. Time of Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	8d. Describe how in	jury occurred and Number or Rural Route Number,
	in 24 hours (the Funeral Interest)	Medical C	29a. Certifier (Check only one) Check only one) Certifying Physician: To the best of my knowledge, death of the basis of examination and/or in and manner stated.	n occurred at the time, date and place, a vestigation, in my opinion, death occurred	and due to the cause ed at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	within 2		29b. Signature and title of certifier Λ.Δ.	29c. License number Δ59062		Date signed (Month, Day, Year)
	Star Registra	te	30. Name and address of person who completed cause of death (Item 23a) (Type, I Chad J. Hanson M.A. 2401 Was 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 2 5 2011 Surve A. Sacres	Print) f Belvedere , Ball		•
DUIS	LI47 D	200	THE NU CUIT CHUNG FG. GRANES		-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Α. McOuaid Gertrude May 6. 7:17 A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Towson Gilchrist Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral (Month, Day, 1 Hours 1 M 2 X F Director 051-26-3511 86 Northern Ireland 1924 Usual Residence of Decedent 28a-f show 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director notified Timonium Marvland Baltimore 1 🗆 Yes 2 🙀 No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? must be Funeral items 23a USA Unit L302 21093 2525 Pot Spring Road death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Black, White, etc. 9 1 X Never Married 2 Married þ Yes 2 X No hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: "natural", 3 Widowed 4 Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.
is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Electrical Business Economist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ellen McKegney William McQuaid permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 16660 Cedargrove Road Sparks, Maryland 21152 Molly R. Hall (Friend) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Gate of Heaven Maus. 1 Burial 2 Cremation 3 Removal from State Hawthorne, New York 5 X Other (Specify) Entombrent 5/26/2011 4 Donation 21204 22. Name and Address of Facility any in Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or it that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery yes 12 months?

☐ Yes 2 No

☐ Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year Pregnant at time of death ed by the detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s or Attending Physician: The law autopsy perform death? 2 No Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 1 Yes Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes injury 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Che crifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d, Date signed (Month, Day, Year) D007128s of person who completed cause of death (Item 23a) (Type, Print) Suite 4501, Baltimore, MD 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 5^{Month} 23 Physician/ Day Robert Nevin Jr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 501 Central Ave SW Glen Burnie Social Security Number If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Min 1 🗶 M 2 🗆 F 3-15-1915 215-01-6654 96 Director Usual Residence of Decedent 10a. State and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural". or items 23a مت 280مة ماس 10b. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location Director MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 501 Central Ave SW 21061 . Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner "natural", or i Completed by 1 Never Married 2 X Married 1 Yes a 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self-employed Gas Station is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert Nevin Mary Mulchacky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary V. Nevin/wife 501 Central Ave SW Glen Burnie MD 21061 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date Page 1; cemetery, crematory or other place)
Glen Haven Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5/26/2011 Glen Burnie, MD 22. Name and Address of Facility 21. Signature of F vice Licenses 421 Crain Hwy SE M01364 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ menna disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and been signed by the attending physician and should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 24a. Was an cate has I page 2 s performed Yes 2 N completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Natural 5 Pending 1 Yes 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \square Homicide determined Medical 29a. Certifier (Check only one 29b. Signature and title of ge address of person who completed cause of death (Item 23a) (Type, Print) 1014 trosbatu an D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

201 Tear

Anne Arundel

Black, White, etc

white

9:30

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 🕅 No

Ам

Kirkley-Ruddick Funeral Home Glen Burnie MD 21061 Approximate Interval Between Onset and Death 54845 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 🗌 Yes Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) Madisa 32. Registrar's Signature **ORIGINAL**

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month S **Physician** 9:20 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NA 17 more 1Altimor RANKLIN Woods If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Days Months 1□M 💥 🗆 F 098-07-8497 June 26,1912 New York 98 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Maryland Baltimore Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21236 U.S.A. 7 Perryoak Place by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. ☐Yes 2 No FYes, Give 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: White Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Casey Theresa Sweeney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 152 Ethel Street, Metuchen, New Jersey 08840 Michael Oberdick 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Marial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State St. Gertrude's Cemetery 5/20/11 |Colonia New Jersey 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marzullo Funeral Chape, P.A. michael 6009 Harford Road, Baltimore, Maryland 21214 23a. Part1. Enter the disease, or copplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner SPHAGIA Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lo s a lense uen Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3□ DOA 1 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Injury at Work? (Month, Day Year) 5 Pending investigation Iniury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical

death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending Physician:

the burial-transit

use a

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been signed by the sahould be detached

certificate

this

within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral

attending physician SB

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural" or flame 2020.

Registrar DHMH 17 Rev 1/2001

To the Hospital

State

LISA 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only one)

30. N. m. and address of person who completed cause of death (Item 23a)

ORIGINAL

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens, State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Month 3:40A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Cecil **Examiner** Elkton 1656 Elk Forest Road If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours (Month, Day, Year) 1 M 2 XF 23-34-242 80 **Director** 0/24/1930 Usual Residence of Decedent ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and items. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Cecil Elkton 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1656 Elk Forest Road 21921 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 SpeWhite 1 Yes 2 No Specify: 3 XWidowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Service <u>Bookkeeper</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Minnie Harvey Burroughs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Daughte‡ Stacy Montgomery/ 1656 Elk Forest Road, Elkton, MD 21921 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ☐ Burial 2 🛮 Cremation 3 ☐ Removal from State Final Journey Crem. 5/23/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21. Signature of Funeral Service Licensee Dorota Marshall 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Physician/Medical Exam Cause (Disease or injury that initiated events resulting in death) Last the burial-trai Due to (or as a consequence of): ed by the attending physician detached for use as the buria Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 - Fetal death in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 Tes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 1 Nursing Home | 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Yes 2 🗷 No မ 1 Inpatient 2 ER/Outpatient 3 DOA after death.

Director: After this within 24 hours after death.

• the Funeral Director: After this
completed filled in by the funeral i 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one the 29b. Signatu and title of c 29d. Date signed (Month, 0 Day, Year) 1 du Name and address of pe 9 32. Registr State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 12:58 A M <u>Michael John Prebish</u> May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard 9837 Old Willow Way Ellicott City Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Month, Day, Jan 26, 1 🛛 M 2 🗆 F Days Hours Min. 1937 Pennsylvania **Director** Yrs. 210-28-9321 Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? r items 23a or ner must be r Funeral 9837 Old Willow Way 21042 United States hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Armed Force Black, White, etc. ò ģ 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: "natural" Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 4 Defense Electrical Engineer event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. other traumatic Mary Kachmar Michael Joseph Prebish 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Suzanne M. Prebish / W</u>ife 9837 Old Willow Way Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🗷 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Journey Crematory 5/24/2011 Woodbine, Maryland Signature of Funeral Service Coing Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence of): disease or condition Medical resulting in death) **Examiner** INTRASTITA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MENTSTATIO MERRAMA Completed 1 ☐ Yes 2 F No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 → No 2 🗌 No the Hospital or Attending Physician: eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 1 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year. 125947 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Date filed (Month, Day, Year)
NAY 25 2011

Evelyn Jackson 5540 Ten Oaks Road Clarksville, MD 21029

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1/16 State 54 May 15 no 1/25 620 the Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **May**Mo**1∕4** 2011 Day Physician/ Catherine Anna Peak 1:05pm Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Baltimore Towson Social Security Numbe 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 M 2 XX Hours June 1935ar 215 30 6082 75 Baltimore, Maryland **Director** Yrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Maryland Baltimore Baltimore County 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 45 Henry Avenue 21236 USA 11. Marital Status Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2XX Married 1 Yes 2XX No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: White Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bank Teller Banking Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Elizabeth Spealman Edward Albert Vanik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
45 Henry Avenue Baltimore, Marylland 21236 Stanley E Peak (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State cemetery, crematory or other pla Gardens of Faith Cem. May 18 2011 Baltimore, Maryland 4 Donation 5 Other (Specify) 21/Signature of Funeral Service Licenses LassahrinForterali Howe Inc. 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line complications that caused the death. Be not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year 2 3 10 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed⁴ 2 🗆 No 1 🗌 Yes Yes 2 N Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 Wo Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Atural injury 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation Director; / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar (Check

only one)

nd title o

KUMAR

MD

701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D71040

29d. Date signed (Month, Day, Year)

7102

29c. License number

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

NORTH CHAPLES ST QUITE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	State of Mary		rtificate of D			eg. No. 2011	16668
	Physicia	n	1. Decedent's Name (First, Middle, La	Pannill				2. Date of Deat Month	Dav Year	3. Time of Death
	/Medic	al -	William 4a. Facility Name (If not institution, given			4b. City, Town, or I	ocation of Death	May 2	0, 2011 4c. County of Dea	8:10 A. M
	Examin	er	Carroll Luthe				minster		Carro	
	Funeral Director		5. Social Security Number 6. S		yrs. last birthday) 2 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 28	Year) C	thplace (State or Foreign ountry) rginia
	and and		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation		-		10d. Inside City Limits
	Maryl H sho	to	MD Carro	11	Westmine	ster				1 □Yes 2 No
	h the	irec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	ountry?
	th wit	Tal [201 St. Mark Way	Apt 406		21158			USA	
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If them 27 is marked other than "natural", or items 23a or 28a-f show if them 27 is marked other than "natural", or items 21a or 28a-f show or other traumatic event, the Madical Evan in the Instituted.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ∑XYes 2 ☐ No If Yes, Give Year or Dates: WW		Was Decedent of His If Yes, specify Cubar 1 □Yes 2█ No	spanic Origin? (Spin, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		te, etc. White
2-0	72 ho "natui	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece	dent's Usual Occupa kind of work done do DO NOT use retired)	ition uring most of worki	ing	16b. Kind of Business	s/Industry
121	filed within Hygiene. other than "	dwc	Elementary/Secondary (0-12)	College (1-4or 5+)	i	itional En			Construct	ion _
<u>0</u>	filed If Hygi other ent, I	BeC	17. Father's Name (First, Middle, Las	")			18. Mother's Name	e (First, Middle, i	Maiden Surname)	
<u>Ilan</u>	should be and Mental marked o	TO B	Alisha C. Pannil				Frances			
lar)	2 sho		19a. Informant's Name/Relationship Mary A. Pannill	(Type. Print) W ife		-			r, City or Town, State,	
(ه	and Health								minster, M	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec.	A Removal from State		osition (Name of matory or other place w. Mem. Pat	9)		Sykesville	
a I	mit. F partm portar y Injur	j	21. Signa of neral Service Lies		2	2. Name and Addres	s of Facility 5 te	rling As	hton Schw	ab Witzke
<u> </u>	Pe E E		Mela	1. 11.	2 1	630 Edmon	deon Ave	nue: Cat	consville,	MD 21228
			23a. Part 1. Enter the disease, or shock, or heart failure. List only	n Tcations that caused the one cause on each line.	e death. Do not en	ter the mode of dying	g, such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Durch	Leegue					Few must
	Examiner			Due to (a) a c	onsequence of):	des ter	44			Such
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a c		5				ο Λ
	ecuted nd transit	Examiner	that initiated events	o. Hem	valle	muum				Luch
60,	icate be executed physician and the burial-transit	EX	resulting in death) Last	Due to (or as a	onsequence of):					
68760,	ficate physi s the b	edical		_d						
O. Box (eath certi attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnancy ☐ Other (s <i>pecify)</i>	У		23d. Date of o	delivery Day Year
σ.	w requires that the desired speen signed by the should be detached		Part II. Other significant conditions	contributing to death but r	not resulting in the u	underlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
rds	quires en sigi uld be	q pe	chel@ cusi	Pheny	Lines	aster	enclina	101	es 2⊠No 3□	Probably 4 Unknown
eco	e law re has beo le 2 sho	Completed by		U				24a. Was autop	sy prior t	autopsy findings available to completion of cause of
<u> </u>	The cate h	Com							rmed? death 2 ZNo 1 □ Y	? es 2□No
Vita	ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:		Other	26. Place of Dea			
of	Phys r this ral dir	-T	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient	2 ER/Outpatie	of 28c. Injur	y at		dence 6 Other (S	pecify)
on	Attending Physician: If death. ector: After this certification by the funeral director.	tion	1 Natural 5 Pending 2 Accident investigati	(Month, Day, Y	'ear) Injury	Work	k? Yes 2 □ No			
Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		- At home, farm, st (Specify)	reet, factory, office		28f. Location (\$ City or Tox	Street and Number or vn, State)	Rural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I		29a. Certifier 12 Certifying	Physician: To the best of	m knowledge, dea	th occurred at the time	me, date and place	e, and due to the	cause(s) and manne	r as stated.
	n 24 hd n 24 hd ne Fun oletely	edical	(Check only 2 Medical Ex	aminer: On the basis of and manner state	xamination and/or i	nvestigation, in my o	opinion, death occu	irred at the time,	date and place, and t	
	Vithin To th	Me	29b. Signature and title of certifier	/ //		29c. Licens	e number		29d. Date signed (Mo	onth, Day, Year)
	m h		•	A.	AX	735	7949		Munde	20011
	81.8.		30. Name and address of person wh	o completed cause of de	in (Item 23a) (Type	rint)		AH	SAH His	21157
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	avens	rence ?	Sulla"	201 W	Many
	Regist		MAY 25 2011 &	una 1. 19	back					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 20. 47 M Norene Phyllis Parthree 05 101 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner ALTIMURE n/a 8. Date of Birth (Month, Day, Year) 3 / 19 / 193 If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🔀 F Hours 217-24-3115 Director 80 MI Usual Residence of Decedent Show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 1 Tes 2 X No Baltimore Catonsville MD 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 Winesap Court, USA Apt J. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify If Yes, Give 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Sales Manager Retail Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Franklin Ward Doris E. Nelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Renee E. Matsis / Daughter Winesap Court, Apt. J. Catonsville, MD 21228 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ■ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) Loudon Park Ceme. 5/25/2011 Baltimore, MD Sundure of Funeral Service Lidensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. any 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition / Medical resulting in death) Due to (or as a consequence of) Examiner WK neumonia Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate
cause (Disease or iinjury Due to (or as a consequence of) Im phome death certificate be executed for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death יט עוד runeral brector: After this certificate has been signed by the (completed filled in by the funeral director, page 2 should be detached q 🗌 Unknown 9 Unknown P.O. To the Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, within 24 hours after death.

To the Funeral Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsv death? 1 ☐ Yes 2 ☐ No Yes 21 No Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospita 2 No မှု 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 12011 20 SLaw 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bailimore MD 2120 900 Cation 5. HIRUY 31. Date filed (Month, Day, Year) MAY 25 2011 32. Registra State

Registrar

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Registrar
DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.O. I

Division of Vital Records,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 10 Amelia M. Rowles PM 2011 23 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Rosedale FRANKLIN SQUARE HOSPITAL CENTER 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country (Month, Day, Year) 1 M 2 F Months Hours Min. 218-22-4546 84 Director Aug8,1926 Usual Residence of Decedent 28a-f shov 10a State 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director Rosedale Baltimore MD 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21237 1217 Gettig Road USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Force Black White etc. þ ☐ Yes 2 🔀 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XIo Specify: Specify: White Completed 3 XWidowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Baltimore County Elementary/Seconday (0-12) College (1-4 or 5+) Cafeteria Worker Public Schools 6th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick Wunder Catherine Carney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto. MD 21237 Gary Rowles /son 5056 Castle Stone Drive 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Gardens of Faith 5/27/11 Rossville MD 4 Donation 5 Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto eral Home of Essex 2 Connelly Funeral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician Sepsis disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Bacteremia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed ENdocarditis Cause (Disease or linjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 3 \square Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Pregnant at time of death / the & signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ myocardial Infarction 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has performed' certificate 2 No 25. Was case referred to medical 26. Place of Death (Check only one) B examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No neral Director: A filled in by the fi 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral Completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier Kollmontil 069198 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANKLINSQUARE DR Balto md 21237 Kottarathil John 9000 31. Date filed (Month, Day, Year) State Registrar

Melia

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201 7/00 Medical 4a. Facility Name (if not institution, dive street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stimore rity Number e (In vrs. last birthday) If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗶 F Month: Hours Min Director RGINIA 28a-f show 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits **Funeral Director** 1 Yes 2 No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 21217 115A 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?.

1 Yes 2 No If Yes, Give 11. Marital Status 14. Race - American Indian, Black, White, etc. 9 1 X Never Married 2 Married by 1 ☐ Yes 2X No Specify: "natural", 3 Widowed 4 Divorced Completed AMERICAN Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. QO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Be aryland 18. Mother's Name (First, Middle, Maid မ 19a. Informant's Name/ tionship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. MARULAND 2/21 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address Signature of Funeral Service License Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician. Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner later attending physician and for use as the burial-transit Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ♣ No Month Day Year the 9 Unknown 9 Unknown cate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009 31. Date filed (Month, Day

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32. Redistrar's

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MehRIZI

11-03622 Eddie Harris Ross Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

ddie Harris Ross	State of Maryland / Department of Health and Mental F 1-For State Certificate of Death Registrar	rygierie Reg.	No. 2011	16673						
Physician ledical Examine	1. Decedent's Name (First, Middle, Lest) Eddie Harris Ross	2. Date of Death Month D May 14, 201	ay Year 1	3. Time of Death 0520 hrs						
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat		4c. County of Death Prince George	's						
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ញ់ ឱ្⊴ី∄ ji Physician	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dunn & Sons 5635 Eads St. NE DC 2001 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart									
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To the Hos within 24 h To the Fur completely	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29b. Signature and title of certifier 29c. License number	at the time, date an	d place, and due to the	e cause(s)						
	O.C.M.E.		May 14, 2011	,						
\e	30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223									
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			For State Registrar	State of M	aryiaiiu /		tificate of E			21		16674
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Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. with the Funeral Director. After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the		4 ☐ Homicide determ			arm, stree	et, factory, office		28f. Location (S City or Tow		mber or Rura	i Route Number,
	Hospit 24 hour Funera sted fille	Medical	(Check 2 Medical E	Physician: To the best of xaminer: On the basis of e.	xamination and/	or investi	gation, in my opinio	n, death occurred at	the time, date a	nd place, and	I due to the ca	use(s) and manner stated.
	To the within: Fo the сотры		only one) 3 L Certifying 29b. Signature and title of certifier	Nurse Practioner: To the	best of my know	wledge, de	eath occurred at the 29c. License				manner as st gned (Month,	
			M M	(/)			05	7727		05	23 11	
	334		30. Name and address of person	ho completed cause of d	eath (Item 23a)		1 4 1	1.46	11	1	10	D 21234
	Stat		31. Date filed (Month, Day, Year)	32 Registre	ar's Signature	Wa	Unan	> WOUC	D M	COX	- 101	1101454
	Stat Registra		HAV OF 2011	A DEL TIOGRAFIA	back							

DHMH 17 Fov 7/2006

		1	Amend Item 20c Ple	per fh.g91 ase Type or Shaten	6,06/06 Frint in TTEM#1 of Marylar	/2011d Black li 9a, per block	hb idelible FH,G915 artmento	Ink, Ens 57257 5Health	Sure A 2011	\II.Copie ∦ental Hy	s Are	e Legible		
Amend Item 20c per fh, g916,06/06/2011dhb Type or Print in Black Indelible Ink. Ensure All Copies Are AMEND TITEM# 19a, per FH, G915,5/25/2011, WS State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death									Reg. No	2011	1 6 6 / 5 3. Time of Death			
	Physicia Medi		RENEE	RC	YAK-SCH	IALER				Month MAY	22ª	y 2011		
100	Examir		4a. Facility Name (if not institution	acility Name (if not institution, give street and number)					of Death		4c	. County of Dea	th	
1000	z.**		HOWARD COUN			COLUMBIA					HOWARD			
	Director						If Under 1 Year If Under 24 Hrs. 8. Date of Bir (Months Days Hours Min. 10 / 00						thplace (State or Foreign nuntry) NJ	
	and show	5	Usual Residence of Decedent 10a. State 10b. Count	у	10c. City, Town or Location								10d. Inside City Limits	
	Maryla 8a-f	rect	MD HO	WARD		ELLICOTT CITY							1 🗆 Yes 2 😾 No	
	h the	<u>=</u>	10e. Street and Number				10f. Zip Coo	de			10g. Cit	tizen of What Co	ountry?	
	th with ms 23 must	Funeral Director	9516 MICHAEL					.042				USA		
<i>'</i>	or itel	by FL	11. Marital Status 1 ☐ Never Married 2 ☐ X Ma	Armed Fo	edent Ever in U.S rces?	S. 13. \	Was Decedent of Yes, specify C	of Hispanic Or uban, Mexica	rigin? (Spe in, Puerto	ecify Yes or No- Rican, etc.)	-	14. Race - Ame Black, Whit		
036	rs afte rral", Exan	ed b	3 Widowed 4 Divorce	If Von Civ	re		∣ Yes 2X	No Specify	<i>י</i> :			Specify:	WHITE	
5-0	2 hou "natu edical	plet		ent's Education lest grade completed)		16a. Deced	dent's Usual Oc	cupation ne durina mo:	st of worki	ina		ind of Business		
21215-0036	ene. than the Me	Completed	Elementary/Seconday (0-12)	-4 or 5+)	life. DO NOT use retired) PROFESSOR			UNIVERSITY OF MEDICAL SCHOOL						
	iled w I Hygi other	Be	17. Father's Name (First, Middle,	5+ Last)	31 110		1			e (First, Middle, Maiden Surname				
ylar	d be f Menta arked atic ev	₽	HYMAN		ROYAK			SALLY				LLER		
Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relation Magda Schaler-I MAGDA ROYAK-SC	ship (Type, Print) Iaynes ,	/pe, <i>Print</i>) 19b. Mailin			ig Address (Street and Number or Rural Route Number						
	and 2 Health		MAGDA ROYAK-SC 20a. Method of Disposition	HALER/DAUG			COOPER sition (Name of							
Baltimore,	age 1 ant of nt: If it y or o		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	3 K Removal from	State C	emetery, cren	natory or other	olace)		Date 5/2011		ocation - City or		
altir	mit. P partme portar / injur		21. Signature of Funeral/Service	1	mı.			1				& BROS		
Ä	Depar Impor any ir		Michael	uge								SVILLE,		
-	Physician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Bone Neoplasm with Metastasis to Brain Due to (or as a consequence of):											Approximate Interval Between Onset and Death Months Atlanta	
		Physician/Medical Examiner	Sequentially list conditions, if any, beauting to immediate Oue to (or as a consequence or).											
8	executed in and ial-transit													
00														
68760			IF FEMALE:	T										
Box (ires that the death certificate be signed by the attending physici id be detached for use as the bu		23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy Month 23d. Date of of Mont								23d. Date of delivery Month Day Year			
P.0	that t ned b e deta									se contribute to	oute to the cause of death?			
ds,	requires been sig should b	ted								No 3□P	robably 4 \(\sum \) Unknown			
The law requires the la								24a. Was auto						
Table 10 O O Company of the part of the pa								performed? death				death?	s 2 XNo	
/ital	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 ☐ No	Hospital:										
of V	y Phys ar this e	e: 10	27. Manner of Death	28a. Date	of injury	28b. Time of	WOutpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Do Time of 28c. Injury at 28d. Describe how injury occurred						ify)	
ono	ending sath. or: Afte ne fun	ficat		igation	h, Day, Year)	injury	injury injury M 1 Yes 2 No					,		
.≥	afte Tin Dir	al Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	To the Hospital within 24 hours a To the Funeral I completed filled	Medical	(Check Medical	g Physician: To the be Examiner: On the bas g Nurse Practioner: I	is of examination	and/or invest	igation, in my or	inion, death o	ccurred at	the time, date a	and place,	and due to the	cause(s) and manner stated.	
	Voit Con		29b. Signature and title of certified	, , ,		UD	29c. License number 29d. Date signed (Month, Day, Year) D0055810 May 22, 2011							
	20		30. Name and address of person										- 01616	
	Stat	e e	Jyothi Rao—Maha 31. Date filed (Month, Day, Year)	92 B	anietrar'e Sianat	Uro	1 Drive	Suite	210	Ellic	cott	City, M	D 21042	
	Registra		MAY 2.5 2011	English &	far	1.0								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 22, 2011 12:30A M Richard Edward Swing Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Casey House If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 1 **X** M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Yrs Director 169-22-6496 1926 Illinois 84 Sept Usual Residence of Decedent show 10b. County ms 23a or 28a-f shor must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2X No Silver Spring MD Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20906 3214 Norbeck Road items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Was Decedent Ever III 0.5.
Armed Forces?

1X Yes 2 No
If Yes, Give
Year or Dates. 1944–46 the Medical Examiner Black, White, etc. ò ğ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Mathematician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frances Boyle Raymond J. Swing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Craig S. Swing/Son 1109 Poplar Grove Ct. Mt Airy, MD 21771 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State Woodbine, MD Final Journey Crematory 05/26/11 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licer coing Home Cremation Service P.O. Box 784 Beverly L. Heckpotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nset and Death **MONTH** Physician/ Intracranial Hemmorrhage disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 1 month Subdural Hematoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a conseque ce attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physicial P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Nuknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed?

1 Yes 2X No 2 No 1 Yes 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? 1 XYes Other: 4 Nursing Home 5 Residence 6 Other (Specify) hospice 2 🗌 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 🔀 No Certificate: 28d. Describe how injury occurred ☐ Natural 5 Pending (unk) 04/22/2011 X Accident Investigation subject fell 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State). Silver Spring 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Assisted Living determined 3214 Norbeck Rd. Maryland Medical 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 To the within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 22, 2011 D37142 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G. Coleman, M.D. 6001 Muncaster Mill Rd. Rockville, MD 20855

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

25 2011

			Plea	ase Type or Pri					-			10077	
	1 - State											16677	
			Registrar 1. Decedent's Name (First, Middle	e, Last)		Cer	uncate of L	Jean	2. Date of Dea	Reg. No.		3. Time of Death	
	Physicia Medi		Jeanne Barbar	a Stark	cloff				Month May	23	$2\overset{\scriptscriptstyle{Year}}{0}11$		
	Examir		4a. Facility Name (if not institution Brightview Assi				4b. City, Town, or Baltimon	Location of Death	4c. County of Death Baltimore				
	Funeral Director		5. Social Security Number 219–18–1002	6. Sex 1 □ M 2 🗓 F	e (In yrs. last 87	<i>birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 27	Year 1923	9. Birth Mar	place (State or Foreign ntry) yland	
	nd now	Ļ	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lor	cation					10d. Inside City Limits	
	larylar Sa-fsl ified	Director	Maryland Baltimore Baltimore									1 ☐ Yes 2 🕅 No	
	the N a or 2		10e. Street and Number		10f. Zip Code					10g. Citizen of	What Cou	ntry?	
	h with ns 23%	Funeral	8100 Rossville	Blvd.			21236			Unite	d Sta	ates	
39	after deat al", or iten Examiner r	ğ	11. Marital Status 1 ☐ Never Married 2 ☐ Mari 3 👿 Widowed 4 ☐ Divorced	If Van Civa	If Yes, specify Cuban, Mexican, Pue				pecify Yes or No- o Rican, etc.) 14. Race - Black, \ Specify:				
ŏ	hours natura lical E	lete	15. Deceder	16a. Decedent's Usual Occupation				16b. Kind of Bus					
21218	vithin 72 jiene. er than "i the Med	Completed	(Specify only higher Elementary/Seconday (0-12)								state government		
land	ge 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If if tem Z 7 is marked other than "hatural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last) Antonio Imbragulio 18. Mother's Name (First, Middle, Maiden Sumame) Jennie Cascio							ne)			
Mary			19a. Informant's Name/Relationship (Type, Print) Kristine Moylan / daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 14 Parkwind Ct. Baltimore, MD 21234								Code)		
Baltimore, Maryland 21215-0036	permit. Page 1 and Department of Hea Important: If item any injury or other once.		20a. Method of Disposition 1 💢 Burial 2 🗆 Cremation 4 🗋 Donation 5 🗆 Other (S	3 Removal from State	20b. Plac	e of Dispos etery, crem	sition (Name of natory or other place	e)	Date	20c. Location			
3alt	permit. Depart Import any inj once.		21. Signature of Funeral Service L	icensee N		J ²²	Name and Addres	s of Facility heII IV. F	uneral S	Services	sofD	ulaney Vall 193 F	
8	Medical Examiner	al Examiner	23a. First 1. Enter the disease, or shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a b. Due to (or a)	a consequence	ce of):	ENSI		, respiratory uni			Approximate Interval Between Onset and Death	
D. Box 68760	Attending Prystolan: The law requires that the death certificate be at death. st death. st death. by the attending physici by the attending physici by the funeral director, page 2 should be detached for use as the bu	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Ectopic pregnanc	Other (specify)			23d. Date of delivery Month Day Year					
ds, P.(v requires that s been signed k should be det	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
Kecor	sician: The law rel certificate has be irector, page 2 sho	Completed							24a. Was a autop perfor 1 🗆 Yes	sy med?	Were auto prior to co death? 1 \(\sum \) Yes	psy findings available ompletion of cause of	
ta .	cian: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			26. Pla	ace of Death (Check	k only one)		_	1 0 1	
> =	ding Pnysician: h. After this certific funeral director,	3: 10	1 Yes 2 No 27. Manner of Death	1 Inpatie	ent 2 ER/ 281	Outpatient b. Time of	t 3 DOA	4 L Nursing Ho	ome 5 Residence 5			Desisted L	
Division of Vital Records, P.O.	or Attending after death. Director: After I in by the fune	Certificate:	Natural 5 Pendin 2 Accident Investig 6 Could 4 Homicide determ	work? M 1 ☐ Yes 2 ☐ No at, factory, office 28f. Location			(Street and Number or Rural Route Number, own, State)						
ָב ב	To the Hospital or Attention within 24 hours after deat To the Funeral Directors completed filled in by the	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									iuse(s) and manner stated	
	Vithi Vothi comi		29b. Signature and title of certifier	re	M	. D	29c. License number 29d. Date signed (Month, Day Year) 5 2 5 11					Day Year)	
	Q		30. Name and address of person v					C	102 53	1:		100	
	01-		Mitul Dave, - M.		-	AT 8	colet Dr.	, suite	LU3 E1	licott	City	, MD 21042	
	Stat Registra	e ar	31. Date filed (Month, Day, Year) NAY 252	11 Jenegistra	r's Signature	gar							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = For State Ragistra Certificate of Death Rag. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 1:50 PZ 2011 **Physician** KATHRYN **GREGORY** SCOTT /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner None Baltimore Roland Park Place If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 04/05/1912 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🙀 F Maryland Yrs. 214-40-5694 99 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 21 is marked other than "natural; or items 23e or 28e-f show any injury or other traumatic avant, the Marylad Examination and injury and other traumatic avant, the Marylad Examination and injury or other traumatic avant, the Marylad Examination and once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ¥Yes 2 No Be Completed by Funeral Director Baltimore Maryland None 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21211 830 West 40th Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Baltimore City Teacher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Bertha Celina Behrens Roland Cruette Gregory 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 830 West 40th Street #856 Baltimore, Maryland 21211 Ruth Scott Mitchell 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition XBurial 2 ☐ Cremation 3 Removal from Druid Ridge Cemetery | 05/26/2011 | Pikesville, Maryland □Donation 5 □ Othe (Specify) 22. Name and Address of Fathtchell-Wiedefeld Funeral Home Inc of Funery Se 6500 York Road Baltimore, Maryland 21212 Approximate Interval Between Onset and Death caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, of shock, or heart failure. List omplication Immediate Cause (Final constory failure Physician disease or condition resulting in death) /Medical pullin ary disease Years **Examiner** Phatricine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760 that initiated events resulting in death) Last Due to (or as a consequence of) Physiclan/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnam 3 Ectopic pregnancy 1 Live birth 2 Fetal death Year Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy 1 ☐ Yes 2 ☐ No 2 No To the Hospitel or Attending Physicien: within 24 hours after death.
To the Funerel Director: After this certifice 26. Place of Death Check onl one 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Mann of Death 28c. Injury at Work? 28d. Describe how injury occurred completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 1 Watural 5 Pending 1 Tyes investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 23, 2011 17 Tanbelle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 700 W. to the STREET, BALTEMIRE, AD 21211 17 HABBUE PACERETICA,

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

2. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Maryland		artment of rtificate of			giene Reg. 2.0	1 16679		
	Physici		1. Decedent's Name (First, Middle, Last) John M Schm; 2.				2. Date of Dea	ath	3. Time of Death Year 425 p M		
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Fairfield Rehab & Nursing Center 5. Social Security Number 6. Sex 7. Age (In yrs. las	t birthday)	Crowi	or Location of Deansville		4c. County of	f Death Arunde1 9. Birthplace (State or Foreign Country)		
	Funeral Director		214-24-3206 12€M 2□F 82 Usual Residence of Decedent	Yrs.	Months Days	s Hours Mir	8. Date of Birt (Month, Da Nov. 2	4,1928 N	Maryland		
Maryland 21215-0036	the Maryland	rector	10a. State 10b. County 10c. City, The Maryland Anne Arundel Pasace 10e. Street and Number	_	10f. Zip Code			10g. Citizen of Wh	10d. Inside City Limits 1 Yes 2 No nat Country?		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural; or Items 23a or 28a-f show eny injury or other treumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	322 Creek Blvd. 11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of	122 Hispanic Origin? (ban, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)		- American Indian, , White, etc.		
	ed within 72 hou ygjene. ier than "natural t, the Madical E.		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Oollege (1-4or 5+) N/A	(Give	dent's Usual Occ kind of work don DO NOT use reti Plumber	e during most of w red)			iness/Industry sher cal Contractor		
yland	ould be fil Mental H tarked ott		17. Father's Name (First, Middle, Last) Edgar Christopher		nmidt	Irene	Rosa1		Buxbaum		
ore, Mar	jes 1 and 2 sh of Health and If item 27 Is m or other treum		Barbara E. Rodbell (Daughter)	927 ce of Dispo			tminster Date	, Marylan	nd 21158 City or Town, State		
Baltimore,	permit. Pag Department Importent: eny injury o		`4 □Donation 5 □Other (Specify) At1 21. Signature of Funeral Service Licensee		Cremat: 2. Name and Add 1cCully-1 3204 Mou				rnie, Maryland A. Iand 21122		
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8760,	death certificate be executed e attending physician and of for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the consequence	nce of):	ral to t	here here	(F	T-)			
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Division of Vital Records,	The law recate has bee						24a. Was auto perfo 1 Yes	psy ormed? de	/ere autopsy findings available rior to completion of cause of eath? ☐ Yes 2 ☐ No		
	ysicien: Th is certificate director, paç		25. Was case referred to medical examiner? 1 Yes 2 Mo	R/Outpatie	nt 3□ DOA		eath (Check only of Home 5 ☐ Resi		or (Specify)		
	iing Ph h. After th funeral	Certification; T	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	28c. Injury at Work? M 1 □ Yes 2 □ No			how injury occurred				
DIV	ospitel or Attend hours after death uneral Director: ly tilled in by the		4 Homicide determined 288. Place of Injury: At hom building, etc. (Specify)	City or To	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	To the Hospitel within 24 hours of To the Funeral I completely tilled	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge of the desired from the basis of examination and manner stated.					date and place, a	nd due to the cause(s)		
)		Σ	29b. Signature and title of certifier		29c. Lice	onse number	93	29d. Date signed	(Month, Day, Year)		
\$	80.		30. Name and address of person who completed cause of death (Item 2	(Type	, Print)	五元	عدماده	Les Co	Dony Drive		
	Sta Registi		31. Date filed (Month, Day, Year) MAY 2 5 2011 Senem 32. Registrar's Signature A grant	No.	***	(i) P+(i)	11.				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 9:27 PM Joseph Spicer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Union Memorial Hospital 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) Months Days Min. 1 X M 2 □ F Now 10 , Year 947 unk Director 216-50-3588 63 Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21218 2700 N. Charles Street unk 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ıral", or iten Examiner r 14. Race - American Indian, Armed Forces' Black, White, etc 1 Never Married 2 Married unk ð Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2 🛣 No Specify: "natural", 3 Divorced 4 Divorced Completed Year or Dates traumatic event, the Medical unk 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 291 E. University Pkwy Baltimore, MD 21218 and 2 s Health a Union Memorial Hospital permit. Page 1 and 2 Department of Healt Important: If item 2 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in state 21. Signature of Funeral Servi State Andresmy Board 655 W. Baltimore Street Director 21201 Baltimore, MD Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shools, if heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate CauserFinal Physician/ disease or condition nummenue down Medical resulting in death) ue to (or as a consequence of) Examiner nown Sequentially list conditions, Lun to (or the consequence of): cause. Enter Underlying Cause (Disease or linjury that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy 5 Other (specify) Month Day Year Pregnant at time of death ned by the a e detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò signe 1 be d Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy performe death? 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical of Vital director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ျ ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work' Division 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nyrse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature ar 29d. Date signed (Month, Day, Year) MD. 15, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL UNION MEMORIAL 31. Date filed (Month, Day, Year) Registrar's Signal State

DHMH 17 Rev 7/2009

Registrar

P.O.

5

11-03355 Katrina Slyke Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month D. May 3, 2011 1538 hrs Medical Examiner Katrina Slyke 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death Baltimore 5120 Woolverton Avenue If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours Months Days Director 577-94-6511 Country) Washington DC 1 M 2 X F 50 Jan 28. Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 1 Yes 2 No 28a-f show Baltimore permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number 5120 Woolverton Avenue 21215 USA Funeral 14 Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married 2 X No Yes 1 Yes 2 X No specify: Specify: black 3 Widowed 4 Divorced If Yes, Give Year <u>۾</u> 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 temp agencies secretarial 18.Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) unk Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ဥ 5120 Woolverton Avenue Baltimore, MD Antionette Ellis/cousin 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State Donation 5 X Other Specify: 11/state 21. Si in ture of Funeral S 23 Name and Address of Facility Board 655 W. Baltimore Street 21201 Baltimore, MD It. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and List only one cause on each line /Medical Death Immediate Cause (Final disease) Acute Bronchopneumonia Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed the attending physician and ed for use as the burial - tran AMENDED 23a, pt. II, 27, per me, g917 7-8-11 sm Physician/Medical X UNPENDED Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Ś 1 Yes 2 No 3 Probably 4 V Unknown Cardiomegaly with biventricular dilatation and Completed 24a, Was an 24b. Were autopsy findings available certificate has been perivascular fibrosis autopsy prior to completion of cause of performed? ✓ Yes 2 No death? 2 No page 1 Yes Fo the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Other Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA After this 1 Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 5 Pending the 2 Accident in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be within 24 hours at To the Funeral I completely filled determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number May 12, 2011 O.C.M.E. (MO) 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Worth, Day, Year, 2011 82. Registrar's Sign arka

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene_ For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 065 FRED (2 HERWIN 20 N Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 729 Dividing Road Anne Arundel Severna park Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) 1 - M 2 F Months Davs Hours Min July 9 Rhode Island Director 579-07-3658 98 1912 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD Severna Park Anne Arundel 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 23a Funeral **USA** 21146 729 Dividing Road within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Was Deceden. ____ Armed Forces? 1 ☐ Yes 2 🔀 No Black, White, etc. "natural", or δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. white Specify Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Men Elementary/Seconday (0-12) College (1-4 or 5+) arts artist/model Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ Florence Winifred Johnson Percy Edward Gould 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Severna apark, MD 21146 John Sherwin/grandson 729 Dividing Road 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☒ Donation 5 ☐ Other Specify) cemetery, crematory or other place) Signatur Funeral Service State Anatomy Board 655 W. Baltimore Street MD Baltimore. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ Ce disease or condition Medical resulting in death) Due to (or a a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a conseque sician and bunial-trans Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No jo Month Day Pregnant at time of death 5 Other (specify) the detached Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. sate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homiçide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To makest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Signature and title of certifier completed cause of death (Item 23a) (Type, Print) MA 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

11-03369 Jeffrey Sears

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death									
Physicia Medical Examir	ın/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year May 4, 2011									
)		4a. Facility Name (if not institution, give street and number) Mercy Hospital 4b. City, Town, or Location of Death Baltimore									
Funeral Director		5. Social Security Number unk 6. Sex 1. Age (In yrs. last birthday) 36 Yrs. If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthday) Foreign Co								9. Birthplace (State or Foreign Country Mary Land	
72 hours after death with the Maryland n "natural", or items 23a or 28a-f show any al Examiner must be notified at once.	by Funeral Director	Journal Residence of Decedent 10a. State 10b. County MD 10e. Street and Number 3538 Hanover 11. Marital Status 1 Never Married 2 Mar 13 Widowed 4 X Divo 15. Decedent's Education (Specific Residuents) Never Married 15. Decedent's Education (Specific Residuents) Never Married 15. Decedent's Education (Specific Residuents) Never Married 16. Decedent's Education (Specific Residuents) Never Married 17. Decedent's Education (Specific Residuents) Never Married 17. Decedent's Education (Specific Residuents) Never Married 17. Decedent Never Married 18. Decedent	12. Was Deced Armed Force 1 Yes orced If Yes, Give Year or Dates:	If Ye	Decedent of H s, specify Cuba	n, Mexican, P specify: ation (Give kin	? (Specify Yes uerto Rican, etc	or No-	14. Race White Specify:	SA - American Indian, Black,	
5-0036 iled within Hygiene. I other tha	Be Completed	11 17. Father's Name (First, Middle, I	O Last)				Name (First, Mic		en Surname))	
		19a. Informant's Name/Relationsh Antonio Sears/	nip (Type, Print)		_	-	et and Numbe	er or Rural Route	e Number,		n, State, Zip Code) MD 21215
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and Important: If item 27 is nigury or other traumaric.	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place)										City or Town, State
	8 8	21. Signature of Funeral Service 15,0113	10000	rector	B	altimor	e, MD	21201			imore Street
Physician /Medical Examiner		fature. List only one cause of Immediate Sussement (Final disease or condition resulting in death)	on each line. a. Heroin Intoxi Due to (or as a co	cation	THO CERTICAL IN	e mode or dying	g, 30011 00 Col	uldo of Foophiato	, a		Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated	b. Due to (or as a co	onsequence of):							
scuted and transit		events resulting in death) Last	Due to (or as a c	onsequence of):							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		UNPENDED IF FEMALE: 23b. Was decedent pregnant in th past 12 months? 1 Yes 2 No 9 Unk	1 Live birt	nt at time of	2 Fel	al death 3 ner (Specify)	Ectopic	oregnancy		23d. Date of Month	delivery Day Year
Division of Vital Records, P.O. B rat or Attending Physician: The law requires that the dersalb. To after death. To Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached it.	Completed by Ph	Part II. Other significant conditi	ions contributing to c	leath but not resu	Iting in the u	nderlying cause	given in Part	1[Yes 2 Was an	No 3	ribute to the cause of death? Probably 4 Unknown Were autopsy findings available prior to completion of cause of
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ician ician s certi	Be	25. Was case referred to medical examiner?	Heenitel:	patient 2 V EF	2/Outpationt		Othor	Nursing Home	5 Pes	idence 6	Other:
n of Vi nding Physi h. After this e funeral dii	ion: To	1 V Yes 2 No 27. Manner of Death Natural 5 Pend	28a. Date o	Injury 28	3b. Time of I	njury 28c. Ir	jury at Work?	28d. Des	scribe how	injury occur	
Divisior pital or Attend ours after death teral Director: filled in by the	ertification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Recreation Area 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 301 Light Street , Baltimore, MD									per or Rural Route Number, Ci
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a. Certifier 1 Certifying Pt one) 2 Medical Example Certifying Pt	hysician: To the best miner: On the basis of and manner sta	examination and/	death occur or investigat	red at the time, tion, in my opini	date and plac on, death occ	ce, and due to th urred at the time	ne cause(s) e, date and) and manne place, and	er as stated. due to the cause(s)
F 2 E 8	Me	29b. Signature and title of certifie					nse number C.M.E.	-		od. Date sign May 5, 20	ned (Month, Day, Year) 11
		30. Name and address of person Ana Rubio MD. Ass	who completed cause sistant Medical E			imore Stree	t, Baltimor	e, MD 2122	3		
S Regis	tate	31. Date filed (Month, Day, Year)	32. Reg	istrar's Signature							

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			for State Registrar	State of Ivi	neaith and i Death	Reg. No. 2011 16684							
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٠,	Examin		4a. Facility Name (if not institution, g	·		4b. City, Town, o	r Location of Death		4c. County of Death BALT (MORE C/				
	Funeral Director	3			e (In yrs. Ia	If Under 1 Year Months Days		8. Date of Bir		9. Birth	place (State or Fore	∍ign	
		ř	Usual Residence of Decedent 10a. State 10b. County			, Town or Loc	eation		1/20	/1920		10d. Inside City Lim	nite
	Maryla 28a-f s otified	Funeral Director	MD N/A		,	ltimo	ore				1 X Yes 2		
	s 23a or		10e. Street and Number 1206 N. Bond	Street	10f. Zip Code 212	13	What Cou SA	ntry?					
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Martla Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ě	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ✗ Divorced	12. Was Decedent E		1	Vas Decedent of H Yes, specify Cuba Yes 2 X No	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Ra Bla Specif	ck, White,	can Indian, etc. ack	
215-(n 72 hou an "natu Medica	Completed	15. Decedent's (Specify only highest Elementary/Seconday (0-12)	grade completed)		(Give k	ent's Usual Occup ind of work done ONOT use retired)	during most of wor	king	16b. Kind of Business Industry			
d 21	ed withir Hygiene other the	Be Co	17. Father's Name (First, Middle, Las	College (1-4 or 5)+)	Ship	oing Cl		no (Eirot Middle		rice Modern Inc.		
ylan	uld be fil Mental narked o	일	Clarence Saur	nders	Myra	s Name (First, Middle, Maiden Surname) a Stanley							
Baltimore, Maryland 21215-0036	and 2 should be fill Health and Mental em 27 is marked o ther traumatic eve		19a. Informant's Name/Relationship Ava Barnes -			and Number or Rural Route Number, City or Town, State, Zip Code) Street Baltimore, MD 21218							
more	age 1 ar ent of He nt: If iter ry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐ Removal from State		metery, crem	sition (Name of natory or other place Vot		Date 5 / 2011	20c. Location	-	own, State	
Balti	permit. F Departm Importa any inju		21. Signature of Funer Pervice Lice			22.	Name and Addre	ss of Facility Ma	rch F/				
H			23a. Part 1. Enter the disease, or co shock, or heart failure. List only	omplications that caused y one cause on each line	the death			timore, g, such as cardiac				Approximate Interval Between	
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	ite be exe hysician i he burial-												
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death, within 24 hours after death, To the Athoris after death, or the charal Director. After this certificate has been signed by the attending physicil completed filled in by the funeral director, page 2 should be detached for use as the but??	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 4 Pregnant at 9 Linknown	2 🔲 Fetal	death 3	Ectopic pregnand Other (specify)	су			ate of deliv	rery Day Year	
P.O.	es that t signed b be deta	l by P	Part II. Other significant conditions			,		ven in Part I. Foulure	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unkn				
ords	w requir	pletec	Coronary Artery Disease, Atrial Fibrillation, 24a. Was an autopsy prior										ole
l Rec	n: The la ficate ha or, page		Pulmonary Iti 25. Was case referred to medical	prectension		eumor	nai		1 🗌 Yes	ormed?	prior to completion of cause of death? No 1 Yes 2 No		
Vita	nysiciai nis certi directo	To Be	examiner? 1 □ Yes 2 □ No	Hospital:	ent 2 🗆 E	R/Outpatien	Oth	Place of Death (Check only one) ther: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)					
n of	ath. : After the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat	28a. Date of injur (Month, Day)	y at 28d. Describe how injury occurred Yes 2 \(\text{No.} \) No								
Divisio	ital or Atter urs after des ral Director lled in by the	al Certificate:											
:	he Hosp in 24 hor he Fune ipleted fi	Medical	(Check 2 L Medical Exa	hysician: To the best of r miner: On the basis of ex urse Practioner: To the b	kamination	and/or investi	gation, in my opinio	on, death occurred a	t the time, date a	and place, and du	e to the ca	use(s) and manner s	tated.
	· M		29b. Signature and the of certifier	MD		-		License number 29d. Date signe					
	P. J.		30. Name and address of person who	o completed cause of de		23a) (Type, Pr	rint)	BALTIMO	0.00	05,16,2011			
# ·	Stat Registra	-	31. Date filed (Month, Day, Year)	32. Registra			OLV D ;	UNLITTE	re ,	MU_2	1239		

11-03688

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Robert B. Seymour Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day May 16, 2011 Robert В. Seymour 1602 hrs **Medical Examiner** 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** Harbor Hospital Center If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 216-82-818 11/10/1965 Country)MD Director 45 1X M 2 F Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location in. 10a. State Linthicum 1 XYes 2 No MD Anne Arundel 28a-f show with the Maryland Director 10g, Citizen of What Country 10f. Zip Code 10e. Street and Number ÚSA 21090 42 Patapsco Road or items 23a 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 12 Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item injury or other frammatic event; the Medical Examiner must bijury or other frammatic event; the Medical Examiner must b Armed Forces? 1 Never Married 2 Married 2 X No Yes Specify: White 1 Yes 2 X No specify: 4 Divorced If Yes, Give Year ≥ 16b. Kind of Business/Industry 16a. Decedent's Usual Dccupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Restaurant 12 Chef 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Roger Benton Seymour Linda Turner Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 305 Charles Hall Drive, Millersville, Brian Seymour / Brother 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 1 Burial 2 X Cremation 3 Removal from State Final Journey Crem. 5/23/2011 Woodbine, MD 21. Signature of Funeral Service Licensee Dorota Marshall

22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death aMultiple Injuries complicated by Cardiovascular Diseases Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and - transit Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED 23a, pt. II, 27, 28a-f, per me, g916 6-21-11 sm X UNPENDED attending physician or use as the burial -Records, P.O. Box 68760, 23d Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Day Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown signed by the all 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Chronic Alcoholism; Diabetes mellitus Completed 24b. Were autopsy findings available After this certificate has been uneral director, page 2 should 24a. Was an autopsy prior to completion of cause of death? performed' 2 No page ✓ Yes 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Division of Vital æ examiner? Other Nursing Home 5 Residence 6 Other: 1 🗸 Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 27. Manner of Death 1 Natural fd 5-18-11 subject suffered multiple falls 1 Yes 2X No after death.

Director: / Pending fd 3:00 pm 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 42 Patapsco Ave. Linthicum Heights, Md. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 24 hours after d Funeral Direct 3 Suicide Could not be Residence determined (Specify) Homicide 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. May 17, 2011 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May 20T1 10:00 A.M Dorothy Loretta Tarbert Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore HeartHomes at Lutherville Lutherville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Country) Maryland 1 🗆 M 2 💢 F (Month, Day, Year) ept. 8, 1915 Hours Min. 95 Director 214-03-4896 Usual Residence of Decedent or 28a-f show 10a. State 10b. County filed within 72 hours after death with the Maryland al Hygiene. A other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at **Funeral Director** 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Maryland Baltimore Lutherville 10e. Street and Number 10g. Citizen of What Country? 1420 Front Avenue 21093 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 💢 Widowed 4 🗆 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 10 years Be other traumatic event, 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked ott any injury or other trans-18. Mother's Name (First, Middle, Maiden Surname) 9 Augustus Willback Genevieve Powers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 East Lee Street #1509 Baltimore, Maryland 21202 Mary Diane Stovall (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Parkwood Cemetery 5-24-11 Baltimore, Maryland Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21. Signature of Funeral Service Licenses 21212 23a. Part 1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each important part of the control of the cause o Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Completed by Physician/Medical Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 Other (specify) Day Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🛕 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral direction. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) CRNP 12080210 Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES ST, SUITE 4105 State 25 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 23 Physician/ Linda C. Truelove 2011 9:15 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 951 Richwood Rd., Apt. D Bel Air Harford . Social Security Number 6. Sex . Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign June 24, 1 M 2 X F Hours Min. Director 406-84-3595 53 1957 Maryland Usual Residence of Decedent shov Page 1 and 2 should be filed within 72 hours after death with the Maryland aţ 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits "natural", or items 23a or 28a-f s edical Examiner must be notified Maryland Harford Bel Air 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 951 Richwood Rd., Apt. D 21014 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 X Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify 3 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 11 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edward Hall Lena Mae Hanna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Walter L. Truelove, Sr./Hus. 951 Richwood Rd., Apt. D, Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May 27, Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 5 Other (Specify) Glen Haven Mem. Park Donation Glen Burnie, Maryland 21. Sign 22. Name and Address of Facility Kirkley-Ruddick 421 Crain Hwy., te of Fur eral S e Licer Funeral Home, P.A. S.E., Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that of ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

The birth 2 Fetal death 5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Yes 2 X No 1 Yes 2 Dunknown been signed by the should be detached significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy performed? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag -invome 1 Yes 2 No as case referred to Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 1 L Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural injury 5 Pending 2 Accident 3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D43303 May 24, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Jeffrey Atkinson, M.D.

8028 Ritchie Hwy., Pasadena, Maryland 21122

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20b.c. per the 916 6-3-11 yt State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ 5:35 pm Pamela Taylor Annette 05 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital 7. Age (In yrs, last birthday, 53 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08–12–1957 Social Security Number 6 Sex 9. Birthplace (State or Foreign **Funeral** North Carolina 1 □ M 2 🛛 F 579-76-4688 Director Usual Residence of Decedent shov 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified 28a-f 1 Yes 2 XNo DC Washington 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 'n must be Completed by Funeral 23a 3088 Staton Glen SE #103 20020 USA ral", or items? Examiner mus death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 🕅 Never Married 2 🗌 Married Page 1 and 2 should be filed within 72 hours after c ment of Health and Mental Hygiene.

The state of the state of the than "natural", or any or other traumatic event, the Medical Examin 2 XNo Yes Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 XNo Specify: If Yes. Give 3 Widowed 4 Divorced Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Laundry Mat Attendent Private 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ella Scott Clinton Taylor Mae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Jacqueline Taylor/ Sister 5042 Silver Hill Ct. #202 Forestville, MD 20747 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State **Landover** Date

 XBurial
 2 □ Cremation
 3 □ Removal from State

 □ Donation
 5 □ Other (Specify)

 Harmony crematory or other place, Department of Important: If any injury or once. Heritage Mem. Park 5-27-2011 Waldorf, MD Signature of F neral Service License 22. Name and Address of Facility Ronald Taylor II FH 700mal 10583 Middleport Ln. WHite Plains, MD 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) a. Gangrene of Feet Medical Due to (or as a consequence of) Examiner Acute Respiratory Failure Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and -transit Diabetes Mellitus, Type 2 that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a I for use as the burial-Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Live Birth 2 - Fetal death Pregnant at time of death Month Day Year ned by the a 1 Yes 2 2 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be de þ Hospital or Attending Physician: The law requires '24 hours after death. Division of Vital Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 XNO 1 Yes 2 X NO Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital: 2 × No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Physis within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🖄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Barbara 05/20/20 0065485 Suparich 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barbara Suparrich Silver Spring, MD 20910 1500 Forest Glen Rd 31. Date filed (Month, Day, Year) State MAY 25 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month_ Physician/ W C Medical Facility Name (if not institution, give street and number) 4cl County of Death 4b. City, Town **Examiner** If Under 1 8. Date of Birth 9. Birthplace (State or Foreign If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) (Month, Day, 1 □ M 2 😾 F Months Days Min Maryland 81 Yrs. 1929 Dec. Director 219-28-7361 Usual Residence of Decedent 28a-f shov 10b. County 10a. State an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2K No MD Baltimore Catonsville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 126 Garden Ridge Road 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married 1 Yes 2
If Yes, Give
Year or Dates Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry Je filed win. Hal Hygiene. Mar than "r (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Social Security traumatic event, the should be filed with h and Mental Hygien 7 is marked other the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Raymond Taylor Helen Mathis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 s nt of Health a : If item 27 i 126 Garden Ridge Road; Catonsville, MD 21228 Maureen S. Erwood Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cem. 5/25/2011 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Signature of Funeral Service L 22. Name and Address of FacilitySterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 /ille, Înc. Catonsvili 23a. Part . Enter the disease, Part. Enter the disease, of complications that chased shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of). Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) by the attending physiciar Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 Wonths?

1 Yes 2 Wo
9 Unknown Month Day Pregnant at time of death 5 Other (specify) signed by the a Id be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performed? Yes 2 No this certificate 2 . No 1 Yes Division of Vital Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 No Other: 1 🗌 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Sother (Specify) n 24 hours after death.

Ne Funeral Director: After the pleted filled in by the funeral Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at Certificate: 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 Yes 2 No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 10 0 29b. Signature and title of 29c. License number Shu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6191 Date filed (Month, Day

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, for State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month .00 Physician/ Year O I I urner D M May Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) County of Death **Examiner** lizabeth Baltimore Baltimore en If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🌠 F Months Days Min Hours Month, Day, Year 729/1923 Maryland 213-20-9797 87 Yrs Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 😾 Yes 2 □ No Baltimore MD n/a 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 3310 Gibbons Avenue 21214 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. P. þ 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates. 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White natural" Completed 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other tha Retail Clothing Sales 12 Sales Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Marshall Hoffman Marion Whittle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet R. Taylor / Daughter 3310 Gibbons Avenue, Baltimore, Maryland 21214 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) 5/25/2011 Lakeview Mem Park Sykesville, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final neumoma Onset and Death Physician/ disease or condition Medical resulting in death) Examiner di Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) burial-transit and Due to (or as a consequence resulting in death) Last Physician/Medical that the death certificate be the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy performed Yes 2 death? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No မ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending Natural Accident 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 35M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2122 332 Benson MD 0 Hvenue 31. Date filed (Morth, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Box 68760

Records,

Division of Vital

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. mend item 8 per fh g916 6-30-11 yt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MaV Month Physician/ 1:45A. 20°11 Carrie M. Westfall Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Future Care Health Nursing Home Dundalk If Under 1 Year If Under 24 Hrs. Authorith, Day, Year) July 8, 1914 Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, Funeral 1 □ M 2 🕱 F Hours West Virginia 216-22-4496 96 Director Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County Director 1 Tes 2 No Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21224 1046 North Point Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White If Yes, Give 3 X Widowed 4 ☐ Divorced Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Textile 8 Loom Operator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Dexter B. Westfall Alda Gillespie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 519 Middle River Road, Baltimore, Maryland 21220 Ronald Westfall 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 5-28-11 Westfall Family Cemetery 4 Donation 5 Other (Specify) Bonnie, West Virginia 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 6009 Harford Road, Baltimore, Maryland 21214 Interval Between Onset and Death Pnysician. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or liniury for use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) 4 Pregnant a 9 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cardinascular 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: Nursing Home 5 - Residence 6 - Other (Specify) 1 Yes 2 No Hospital: ဂ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death them 23a) (Type, Print) MARDON 617 31. Date filed (Month, Day, Year) State MAY 25 2011 Registrar

11-03467	
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	ysici	an/	Decedent's Name (First, Mide	dle,Last)					Date of Dea Month	Day Year	3. Time of Death 1900 hrs
Medical E	:xamı	ner	Hauson Tiaree 4a. Facility Name (if not instituti	Woodard	imbor)		4b. City, Town, or L	ocation of Death	May 8, 20	4c. County of	
			University Hospital		N/A	bouti					
Fui	neral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24Hrs	s. 8. Date of Bi		Birthplace (State or
	ector		212-08-9556	1 2	26	Yrs	Months Days	Hours Min		13,1984	Foreign Country)Maryland
			Usual Residence of Decedent	M. Committee				<u> </u>	TILCE.	13,1301	
	w any		10a. State 10b. County		10c. City	, Town or Locat	ion				10d. Inside City Limits 1 Yes 2 X No
yland	once.	Þ	Maryland Harfo 10e. Street and Number	rd	Abe	rdeen	10f. Zip Code			l 0g. Citizen of Wha	
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with th	s 23a e noti	Funeral Director	48 Great Oaks Drive 21001 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (1)							USA - 14. Race -	American Indian, Black,
leath 1	r item	au	1 Never Married 2 N		orces?		es, specify Cuban,			White,	etc.
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hours	Fram	ed	15. Decedent's Education (Sp				it's Usual Occupations ost of working life. I			16b. Kind of Busi	iness/Industry
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15-0036 fled within 72 hours after death with the Maryland Hurisms	other than "natur the Medical Exam	Completed	12th grade 17. Father's Name (First, Middle	e, Last)		Tracto	r Traile	C Driver 8.Mother's Name	(First, Middle,	B.H Tro Maiden Surname)	ICKING
N 2	nt,	Be	Jimmie Woodan	đ				Ophelia	J. Sim	pson	
22 hould	is ma	의	19a. Informant's Name/Relation	ship (Type, Print)						mber, City or Town,	
re, MD 21. 1 and 2 should to	tant: If item 27 is m or other traumatic	ŀ	Ophelia J. Mc 20a. Method of Disposition	Farland/Mc	ther		eat Oaks ition (Name of cem		berdeen Date	MD 21001	City or Town, State
			1 X Burial 2 Crematic	n 3 Removal fr	om State	crematory or oth	ner place)		5-14-2011		
fim it. Pa	Important:		4 Donation 5 Other S		\$t.	James A.M	I.E Church (lame and Address o	demetery	atman_H	Havre de	e Grace,MD neral Home
Perm Perm			(uller t	Dam	>					ltimore,	
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	dical niner		Immediate Cause (Final disease	Advisor to the termination of the Control of the Co	uries						Death
			or condition resulting in death)	Due to (or as a	consequence of	of):					
		힐	Sequentially list conditions, if any, leading to immediate		consequence of	of):					
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uted	ld ransit	EX	events resulting in death) Last	d.	consequence	<i>.</i> ,					
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certificate	e attending phy for use as the b	ig.	past 12 months?	I I Tive p	irth ant at time of de	ath -	tal death 3 L her (Specify)	Ectopic pregna	ancy	Month	Day Year
Box 6876 e death certificate	the atte	Physician/M	1 Yes 2 No 9 Ur	known 9 Unkno	wn	J Oil	ner (opecity)			ĺ	
of Vital Records, P.O. Box is Physician: The law requires that the death	چ چ ت	by P	Part II. Other significant condi	tions contributing to	death but not r	esulting in the u	ınderlying cause giv	ven in Part I.			ute to the cause of death? Probably 4 Unknown
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Division of Vital Records, tal or Attending Physician: The law requires sheet clear	2 6	Completed							autor	osy pri	or to completion of cause of ath?
Rec	or: After this certificate I the funeral director, page	5							1 🗸 Yes		Yes 2 No
ita idi	s certi	<u>m</u>	25. Was case referred to medical examiner?	Haspital:	npatient 2	ER/Outpatient		of Death (Check	only one) ng Home 5	Residence 6	Other:
of V g Phy	After this uneral dir	밁	1 Yes 2 No 27. Manner of Death	28a. Date	of Injury	28b. Time of I		at Work?	28d. Describe	how injury occurred	1
C =	the fu	įį		ding May 8, 2	Offi Tean	1716 hrs	1 Ye		Subject mo	torcyclist invol	ved in motor vehicle
Visi	Direct in by	Certification:	3 Suicide 6 Cou	ild not be 28e. Place	e of Injury - At h	ome, farm, stree	et, factory, office bu				or Rural Route Number, City
Spital	neral Dir filled in	S	4 Homicide			d / Highway			1834 Pulaski	Highway, Havre	
Div To the Hospital or within 24 hours afte	To the Funeral Director: completely filled in by the	ical	(Check only	hysician: To the bes aminer:On the basis of	-	-					
To 1	To	Medical	29b. Signature and title of certifi	and manner s			29c. License				(Month, Day, Year)
			1/1 V	11/	TO	λ	O.C.M	I.E. 0	CME	May 9, 2011	
		ŀ	30. Name and address of person	who completed caus	e of death (Item	1 23a)					
			Theodore M. King, Jr				900 W. Baltimo	ore Street, B	altimore, MI	D 21223	
5	St Regist		31. Date filed (Month, Day, Year)	32. Re	gistrar's Signati	parkel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 19 2011 Charles Ronald Wagner 11:25 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Baltimore ManorCare of Dulaney Towson Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** nth Day, Months Days Hours ^{Year)}938 1 🗶 M 2 🗆 F **Director** Arkansas 569-44-1364 Jun Usual Residence of Decedent show 10b. County notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2X No MD Anne Arundel Hanover 10e. Street and Number ò 10f. Zip Code 10g, Citizen of What Country? 1 and 2 should be filed within 72 hours after death with the if Health and Mental Hygien.

The first 23a or other transfer of thems 23a or other traumatic event, the Medical Examiner must be other traumatic event, the Medical Examiner must be Funeral 21076 USA 7302 Family Acres Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No
If Yes, Give
Year or Dates. 1956–60 Black, White, etc. 1 Never Married 2X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Plumbing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ted Wagner Bernice Bartlette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7302 Family Acres Rd. Hanover, MD 21076 Linda Cannoni/wife 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of F
Important: If ite
any injury or ot Date 20c. Location - City or Town, State 1 🔲 Burial 2 💢 Cremation 3 🗀 Removal from State cemetery, crematory or other place) Final Journey Crematory 05/25/11 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Cerebrorascular Immediate Cause (Final Accident Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ypentension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Hupalipidemia Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): anding physician use as the burial Physician/Medical mellitus Diabetes Hospital or Attending Physician: The law requires that the death certificate be Innt Box 68760 use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death
Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed cate 2 No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: At completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 05-23-11 ress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and ad 7505 wo dslex Himmura 32. Regi Date filed (Month, Day, Year) State 5 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death RAYMOND Physician/ Month WillGING 20 Day 9:25 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death RUN HOWARD GRAYTON Ellicott Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Days 69 JEW YORK 468-46-1266 **Director** Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. The state of Health and Mental Hyglene. The state 18 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Ellicott City MD Howard 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 11979 Grayton Run 21042 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) University Professor 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Pauline Mary Mast Herbert M. Willging 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11979 Grayton Run Ellicott City, MD 21042 Monika Willging/wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of I Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Final Journey Crematory 05/25/11 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) If Funeral Seprice L 21. Signatu Going Home Cremation Service P.O. Box 784 MO1251Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ non-Hodgkins eripheral disease or condition Medical resulting in death) Due to (as a consequence of): Examiner ears Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Due to for as a consequence of, Exami Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be table hours after death.
Panneral Director: After this certificate has been signed by the attending physicial eted filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ☐ Live Birth 2 ☐ Fetal deal ☐ Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No Yes 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 MResidence 6 Other (Specify) 2 No ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined completed filled in Medical 29a. Certifier 1 🗡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the Pwithin 2 only one) 29b. Signature and title of certifier 29c. License number D0059113 05/23/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LODE J. SWINNEN, JOHNS HOPKINS CANCER CENTER, 1650 ORLEANS ST BALTIMORE MD 2/23

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ GERALD O. WILLIAMS 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GOOD HOSPITAL BALTIMORG SAMARITAN BALTIMORE 5. Social Security Number 8. Date of Birth (Month, Day, Oct. 23, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Days Country) V**ir**ginia Months Hours Min. Director 226-56-8655 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ital Hygiene. ed other than "natural", or items 23a or event, the Medical Examiner must be i Funeral 8710 Emge Road 21234 USA Page 1 and 2 should be filed within 72 hours after death upent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner. mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 🖾 Yes 2 🗌 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Meat Packing Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Rufus Williams, Jr. Frances M. Ricks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maude Conaway - Sister 22327 Barn Tavern Rd., Courtland, VA 20b. Place of Disposition (Name of cemetery, crematory or other place)
Care Memorial 20a. Method of Disposition 20c. Location - City or Town, State ! 🔽 Purial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or once. May 26,2011 Courtland, Virginia 4 Donation 5 Other (Specify) Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Engram Funeral Home 1001 Armory Drive, Franklin, VA 23857 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death Immediate Cause (Final Physician/ Acute Hemorrhagic Stroke disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) signed by the attending physician and be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day g Unknown Hospital or Attending Physician: The law requires that the t24 hours after death.
Funeral Director: After this certificate has been signed by th Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Renal Disease, Chronic Division of Vital Records, 1 🗌 Yes 2. No 3 Probably 4 Unknown cate has been si Completed Pulmonary Disease, Seizure Disorder, Diabetes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Hypertension, Penpheral Vascular obsease 1 ☐ Yes 2 ☑ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2- No 1- Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 \square Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Praction of The basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 2011 RES OOU

State Registrar ZIN

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

DHMH 17 Rev 7/2009

State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 0 . Decedent's Name (First, Middle, Last) Kamari 2. Date of Death 3. Time of Death Woods Month Day 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6 conge's 140501 Chever Prince If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign MD ountry) ige (In yrs. last birthday) 8. Date of Birth 212-75-4521 1 □ M 2 🖾 F Months Hours Min. 0 M9/1 Pay 2006 Usual Residence of Decedent 10b. County 10c. City, Town or Location Capitol Heights 10d. Inside City Limits X 1 ☐ Yes 2 ☐ No Prince Georges 10g. Citizen of What Country? 10e Street and Number Zip Code 20743 #402 6806 Central Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 HNo Specify If Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Pre-Kidnergarten College (1-4 or 5+) None None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LaShawn Covington Akil Woods ^{19a.} Informant's Name/Relationship (*Type, Print*)/Mother LaShawn Covington/Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 6806 Central Ave. Capitol Heights MD 20743 20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Dat 2011 20c. Location - City or Town, State Washington Nat. Suitland MD 18, May 4 Donation 5 Other (Specify) 22. Name and Address of Facility Dunn&Sons 5635 Eads St. NE Washington, DC 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Multo disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):

Ph. sician/ Medical Examiner

Physician/ Medical

Examiner

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Department of Health Important: If item 27 any injury or other to once.

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must be notified

Page 1 and 2 should be filed within 72 hours after death with the Maryland

21215-0036

Baltimore, Maryland

To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran attending physician Division of Vital Records, P.O. Box 68760 for use as the detached signed by t d be detach cate has by page 2 s certificate

funeral director.

After this

24 hours after death.

Funeral Director: A

within 24 hours after death To the Funeral Director: of completed filled in by the

Medical

29a. Certifier (Check only one)

29b. Signature and title of certifier

Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Yes 2 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Be 25. Was case referred to medical examino? Hospital မ 1 Inpatient 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 1 - Natural 5 Pending 2 Accident MAY 10, 2011 Investigation 3 Suicide 4 Homicide 6 Could not be

23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death Pregnant at time of death

3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___

23d. Date of delivery Month Day

> 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

Year

2 No Yes 1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify ER/Outpatient 3 DOA 28d. Describe how injury occurred 5774CK

28c. Injury at work? 1 ☐ Yes 2 ☐ No injury 33 2 M 28e. Place of Injury - At hor building, etc. (Specify)

28b. Time of

2011

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number of Building, etc. (Specify)

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number of City or Town, State)

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number of City or Town, State)

28f. Location (Street and Number or Rural Route Number of Rural Route Number of City or Town, State)

28f. Location (Street and Number or Rural Route Number of Rural Route Number of City or Town, State) 29d. Date signed (Month. Dav. Year)

ss of person who completed cause of death (Item 23a) (Type, Print)

^{Yeár}) 31. Date filed (M 2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month May 21 Pay 20**1**1 WITCZAK 5:13 Ам WALTER WILLIAM SR Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 341-18-4572 1 XM 2 D F Days Hours Min. Director 92 10/30/1918 Usual Residence of Decedent or 28a-f show should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits MD Frederick Frederick 1 XYes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21703 "natural", or items 23a Funeral 602 Humberson Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Painter Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Zwieszynski William Witczak Mary permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City, or Town, State, Zip Code) $602\ Humberson\ Lane,\ Frederick,\ MD$ Walter Witczak Jr./Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Termation 3 Removal from State remetery, crematory or other place)
Final Journey Crem. 5/26/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services PO Box 1413, Baltimore, MD pulliall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each Interval Between Preumonia Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ rady cardia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Distress 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s autopsy perform death? DOKIO certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medifuneral director. Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes 2 No Other: ၉ ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work n 24 hours after death.

The Funeral Director: A pleted filled in by the funeral pleted filled fil 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Griffing Nurse Practionar to the cause of th within 24 ho

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completed fi (Check 29b. Signature and title of certifier 29d. Date 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Matthew 400 cunte State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 16700 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MAY 2011 BERNARD 08:20A Medical WILKINS 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TOWSON ler 1 Year I If Under 24 Hrs. GILCHRIST HOSPICE CARE BALTIMORE . Age (In yrs. last birthday **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 1**X**□ M 2 □ F Months Hours 213-24-9404 **Director** 88 11/716/1922 PA Usual Residence of Decedent 28a-f show 10a. State 10b. County must be notified at 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits **BALTIMORF** 1 Yes 2 V No TOWSON 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 800 SOUTHERLY ROAD, #604 21286 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give ori Be Completed by Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 ₩ Widowed 4 Divorced WHI TE Specify: Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)
5 + Elementary/Seconday (0-12) traumatic event, the DENTIST MEDICINE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 **ISADORF** WILKINS RESNICK ROSE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health J. RICHARD WILKINS/SON 18811 FORESTON ROAD, HAMPSTEAD, MD 21074 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o once. 1 🂢 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) BALTIMORE HEBREW CEM. 05/24/2011 REISTERSTOWN. 21. Signature Funeral Service dicensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. call 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ Sepsis disease or condition relics Medical resulting in death) Due to (or as a consequence of): Examiner COUTTS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month 1 Yes 2 9 Unknown 2 No Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 23e. Did tobacco use contribute to the cause of death? venul fujul Veners terrombisis 2 ☐No 3 ☐ Probably 4 ☐ Unknown lymphocytic lerkemiz 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) မ 1 🗌 Yes 2 [] NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 24 hours after death.
Funeral Director: A leted filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 2 🗌 No Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho

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completed fi 2 Medical Examiner: On the pasis of examination.
3 Certifying Nurse Practioner: To the best of my kn 29b. Signature and title of certifier V who completed cause of death (Item 23a) (Type, Print) Pate State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05 03:32 2011 Medical 4a. Facility Name (if not institution, give street and number) County of Death 4b. City, Town, or Location of Death 4c. Examiner Hospital Samavitan G-00 d Beldinove If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral M 2 □ F Months Director d Usual Residence of Decedent or items 23a or 28a-f shov Department of Health and Mental Hygiene important, or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Completed by Funeral Director Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2/2 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working jife. PO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) ntertainer Be Maryland Eather's Name (First Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code mie Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery, cremators or other place) Burial 2 Cremation 3 Removal from State 5 Other (Specify) 4 Donation Part I Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Jepsis disease or condition Medical resulting in death) Examiner lostridium Sequentially list conditions Examiner if any, leading to inimediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Meta bolic attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician; The law requires that the death certificate be exe Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Day Year 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director; After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) မ 1 🗌 Yes Other: 1 patient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural injury work? 2 Accident
3 Suicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 05,20,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD21239 BLud Raven Cahr 5601 Loch Abou 32. Registrar's Signature 5 20 State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

TOTAL MENOSA ANEN	1	- For State Registrar	Stat	e or maryiand	•	rtificate of		and Men	tai i iygic		2U1	16/02	
Physician	/	Decedent's Name							i M	ate of Death	Dav Year	3. Time of Death 0434 hrs	
Medical Examine		April 4a. Facility Name (i	M.	Allen		4	b. City, Tow	n, or Location of		ay 11, 20	111 4c. County of Dea		
		Laurel Regional Medical Center Laurel									Prince Georg	ge's	
Funeral Director													
any	_										10d. Inside City Limits		
and f show	5	MD	PG			Laurel						1 X Yes 2 No	
the Maryland a or 28a-f sh iffied at one	3	10e. Street and Nur		Coach Rd.			10f. Zip Co	20748		10	g. Citizen of What Co	untry?	
		11. Marital Status	id beage	12. Was Decedent	Ever in U	.S. 13. Was	Decedent	20 / 40 of Hispanic Orig	in? (Specify	Yes or No-	USA 14. Race - Ame	erican Indian, Black,	
or items 23	A D	1 X Never Married 2 Married 1 Yes 2 3 Widowed 4 Divorced If Yes, Give Year or Dates:						Cuban, Mexican			White, etc.		
s after ural", c	<u>-</u>						- A				Specify: Bla 16b. Kind of Busines		
72 hour	Pare	15. Decedent's Education (Specify only highest gibble Elementary/Secondary (0-12) College				16a. Decedent's Usual Occupation (Give kind of v during most of working life. DO NOT use reti				iorie	TOD. KING OF BUSINES	ormadal y	
5-0036 ed within 72 hour lygene. other than "natu		4				Bartender					TGIFrida	ys	
21215-0036 July be filed within 72 hours at Mental Hygiene. marked other than "natural cevent, the Medical Exemin		17. Father's Name (st) Allen	Jr			18.Mother	•	t, Middle, M	aiden Surname) Smith		
212 tould be d Ment is mark	2 ┌	19a. Informant's Na	me/Relationship	(Type, Print)	UL		Address (Route Numb	per, City or Town, Sta	te, Zip Ccde)	
e, MD 2 I and 2 shou Health and I fitem 27 is in traumatic		Charles A		./ Father	20h	11706 Place of Disposi			Ct. Bo		MD 20720 20c, Location - City	or Town State	
Baltimore, permit. Pages I at Department of Her Important: If ite injury or other tr		1 X Burial 2	Cremation	Removal from Sta	ate	crematory or oth	er place)						
Baltimore permit. Pages 1 Department of H Important: If i		4 Donation 5 2. Signature of Fu			на	ermony Me			5-19-1 Ronald		Landover, or II FH	MD	
E P P P	ľ	Konde	dib	FIR							Plains,		
Physician VMedical	1	23a. Part I. Enter th failure. List on	ly one cause on	nplications that caused each line. Conges	tive	heart :	ailur	e due t	o hype	ertens	sive	Approximate Interval Between Onset and Death	
xaminer		Immediate Cause (or condition resultir	Final disease ng in death)	a. Cardiovas Due to (or as a conse			e and	hypers	<u>ensiti</u>	vity l	Myocarditi	s	
	Sequentially list conditions, b.												
ted nsit	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated C												
and and transit		events resulting in		Due to (or as a conse d.	equence o	of):							
60, ate be execut physician and he burial - tra	☐ AMENDED 23a,pt.II,27,per me,g916 6-17-11 sm												
ox 68760, ath certificate be extated attending physician or use as the burial-efrican/Modic.	D 1	F FEMALE: 3b. Was decedent		23c. If yes, outcor	ne of preg		al death	3 Ectopic	pregnancy	_	23d. Date of deliver	Day Year	
Box 687 death certific the attending p of for use as th	2	past 12 months	s? No g ✔ Unkno	4 Pregnant at	time of de		er (<i>Specify</i>		programoy		WOTE		
. Box 687 the death certific by the attending p cheed for use as the				g Unknown s contributing to deat	but not r	resulting in the u	nderlying ca	use given in Pa	ırt I.	23e. Did tob	pacco use contribute	to the cause of death?	
Division of Vital Records, P.O. ral or attending Physician: The law requires that it is after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted by B	2		d Obesit				3700			1 Yes	2 No 3 Pr	obably 4 Unknown	
Records, The law requires, figate has been significate bear significate has been significant bear and the second bear and the	alaic		•						1	24a. Was a autops		autopsy findings available completion of cause of	
Reco	5									perform Yes 2	ned? death?		
ital Reinician: The scertificate rector, page		25. Was case reference examiner?		Hospital:	nt 2 🚅	ER/Outpatient		Place of Death Other	(Check only o	-	Residence 6 Ott	ner"	
of VI	- -	1 Yes 27. Manner of Deat	2 No h	28a. Date of Inju (Month, Day,Y		28b. Time of In		: Injury at Work			ow injury occurred	OI.	
ion frendir feath. for: A		1 X Natural 2 Accident	5 Pending	ation			1	Yes 2					
Division o Spital or Attending sours after death. neral Director: After filled in by the fune	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc.									Location (Stor Town, St	on (Street and Number or Rural Route Number, City vn, State)		
File bound		4 Homicide 29a. Certifier 1		Ician: To the best of m	y knowled	lge, death occurr	ed at the tir	ne, date and pla	ace, and due	to the cause	e(s) and manner as st	ated.	
To the Ho within 24 To the Fu completely	֝֞֝֞֝֟֝֝֟֝֝֟֝֝֟֝֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	one) 2 🗸		ner:On the basis of exa and manner stated.	mination a	and/or investigati			curred at the	time, date a			
									License number O.C.M.E.			fonth, Day, Year)	
30. Name and address of person who completed cause of death (Item 23a)										May 12, 2011			
		Melissa Bra	ssell, MD	Assistant Medical	Exami	ner 900 W	Baltimo	re Street, B	altimore, l	MD 2122	3		
Stat Registra		31. Date filed (Mont	9 2011	32. Registra	Signat	faces							

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month AM Medical Facility Name (If not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 579/34/5295 1 - M 2 F Months Min. Month, Day, Year) 26 Hours Washington DC **Director** Usual Residence of Decedent 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md Anne Arundel Glenn Burnie 1 X Yes 2 No 10e. Street and Numbe items 23a or ner must be n ō 10f. Zip Code 10g. Citizen of What Country? Funeral 7885 Gordon Court USA 21060 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, er than "natural", or iter the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Black 3 XXWidowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) House Wife Domestic 12 event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file rand Mental Fis marked or ၉ permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic e George Thomas other traumatic Lena Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Wayne Barnett, Son 9701 Old Allentown Rd Ft Wash Md 20744 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5/19^D/2011 1 Burial 2 Cremat m State Cheltenham Cemetery (Specify) Cheltenham Maryland 4 Donation 21. Signat 22. Name and Address of Facility Ronald M Taylor 11 Funeral Homes 10583 Middleport Lane White Plains Maryland 20695 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition 16 Medical resulting in death) Due to ras a consequence of) Examiner Sequentially list conditions if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence on Examir The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> Completed 1 Yes 2 No 3 Probably 4 Unknown Should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform certificate 1 Yes 2 No Yes 2 No or Attending Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 M No မ Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death. Director: After this funeral 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred work? 1 \(\text{Yes} \quad 2 \(\text{No} \) 1 Natural 5 Pending injury filled in by the Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) D6 408 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 Medica 💪 Signa State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 1- State TCHD, 05/16/2011, TLS Amended, #5, Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 0850 M 28 3011 CATHERINE BURROWS BRADFORD Apri I /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner General Dorchester Hospital CAMBRIDGE 52SpgalSy6viiy1v9g1v9 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Months Days 1 □ M 2 👿 F MARYLAND 48 71 01/03/1940 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits or items 23a or 28a-f show direct must be riotified at 1 XYes 2 No Director MD DORCHESTER CAMBRIDGE 10g, Citizen of What Country? 10e Street and Number 10f. Zip Code 21613 UNITED STATES 103 RAMBLER ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 0 215-0036 1 ☐Yes 2X No WHITE ≥ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 h Elementary/Secondary (0-12) College (1-4or 5+) 12 ADMINISTRATIVE ASSISTANT MEDICAL 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be Mental CHARLES THOMAS BURROWS IDA MARIE SARD Pages 1 and 2 should permit. Pages 1 and 2 shoul Department of Health and M Important: If item 27 is marl any injury or other traumati 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 29509 RABBIT HILL ROAD, EASTON, MD 21601 DENNY W. BURROWS / BROTHER Baltimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition CHESAPEAKE CREMATION 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) MAY 2, 2011 STEVENSVILLE, MD CENTER 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON ST., EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Non small cell lung Conce **Physician** Metastahz disease or condition resulting in death) /Medical Due to (or as a consequence of): Seudomenhonau Colins Examiner Egypentiany flat or offices, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 □Yes 2 □No the 9 Unknown ģ s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ HO 24a Was an has autopsy 1 ☐ Yes 2 = No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₩o 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide e Funeral I 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

BYRN ST CAMBRIDGE MD 21613 THANKY 503 32 Registrar's Signat

DHMH 17 Rev 1/2001

D47924

29d. Date signed (Month, Day, Year)

11-03449 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Herbert Brandford State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month D. May 7, 2011 2022 hrs **Medical Examiner** Herbert Leroy Brandford 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore** University Hospital Baltimore If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director 219-42-2532 Dec 23, 1944 Country) MD 66 1**X** M 2 F Yrs Usual Residence of Deceden 10d. Inside City Limits Iny 10c. City. Town or Location 10a State Glen Burnie 1 X Yes 2 No Anne Arundel MD or items 23a or 28a-f show it. Pages I and 2 should be filed within 72 hours after death with the Maryland riment of Health and Mental Hygene.

Irrant: If item 27 is marked uther than "natural", or items 23a or 28a-f she y nr other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21060 201 Scott Avenue USA Funera 14. Race - American Indian, Black, 11. Marital Status 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married Yes Black 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify. 5 15. Decedent's Education (Specity only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Government Baltimore, MD 21215-0036 Electrician 12th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elsie Duckett Charles Brandford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 Scott Avenue, Glen Burnie, Maryland 21060 Margaret A. Brandford / Wife 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 05/19/2011 Landover, Maryland Harmony Cemetery 4 Donation 5 Other Specify. 22. Name and Address of Facility J. B. Jenkins Funeral Home 21. Signature of Euneral Service Licensee 7474 Landover Road, Landover, Maryland 20785 23a. Parth. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** Between Onset and /Medical a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): ne if any, leading to immediate cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and Physician/Medical AMENDED 23a, 27, 28a-f, per me, g917 7-28-11 sm X UNPENDED attending physician for use as the burial -Box 68760, IF FEMALE: 23d. Date of delivery 23c, If yes, outcome of pregnancy 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Year Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, P.O. ξ 1 Yes 2 No 3 Probably 4 ✓ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? 2 No ✔ Yes 2 No 1 Yes To the Hospital or Attending Physician: 26.Place of Death (Check only one) 25. Was case referred to medical Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 🗌 DOA Other Nursing Home 5 Residence 6 Other 1 🗸 Yes 28d. Describe how injury occurred subject driver of vehicle involved in motor After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Natural Division 5 Pending 1 Yes 2 X No death. the vehicle accident Director: fd 5-7-11 fd 1856 hrs 2 X Accident by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 103 Scott Ave. determined within 24 hours a (Specify) roadway Homicide <u>Glen Burnie,Md</u> 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

AV 18 2011

August B. Factor

30. Name and address of person who completed cause of death (Item 23a)

Theodore M. King, Jr., MD.

OCME

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

OCIME

May 9, 2011

State Registrar Johannad

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For AMEND#8, 20b per FHState of Maryland / Department of Health and Mental Hygiene State Registrar 5/18/2011 AACO HEALTH DEPT. CMH Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ 0735 M IETO RIA 0.5 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Davidsonville Anne Arundel 683 Santa Maria Lane If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5/5/1918 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours (Month, Day, Year, Massachusetts 93 031-05-6608 Director Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 X Yes 2 No Florida Pinellas Clearwater 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral items 23a 33755 USA 1947 Stardust Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 0 Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates White "natural", 3 X Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical Injury or other traumatic event the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Secretary Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Helen Bakun Onufry Jakusik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 683 Santa Maria Ln., Davidsonville, MD 21035 Susan Kilby/ Daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Natl. Cem. Arlington, VA mik . Signatura 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unite lying Cause (Disease or iinjury that initiated events supplied to be a sequential or cause (Disease). Examine Due to (or as a consequence of) the attending physician and thed for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 month Month Day Pregnant at time of death 5 Other (specify) page 2 should be detached Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Completed ARKINSON'S 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has After this certificate ☐ Yes 2 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 1 Yes Daughter's Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death. To the Funeral Director; A Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29h Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year, 8 Name and address of person who completed use of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day,

32.

9 2011

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death CHAMBERLAIN Physician/ · M · 4-2011 00.57 ANDACE 05 Ö Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner manyland Hospital NOTUIL Southern SHULD Y last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthmace (State **Funeral** Months Davs Hours Maryland 215 70 7811 Director 07 10 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a State must be notified at **Funeral Director** ACCOKEEK Prince Georges 1 Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 2060= items 23a United States tarmington Creek 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11. Marital Status the Medical Examiner Armed Forces? 0 þ 1X Never Married 2 Married Yes 2 😾 No White Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates Specify: "natural", Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Horticulture Horticulturist permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry Blaine Chamberlain Smoots Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert K. Chamberlain/Brother 20 Potomac Avenue, Indian Head, MD 20640 Baltimore, 20b. Place of Disposition (Name of Geomet Washaton University Medical Center 20c. Location - City or Town, State 20a. Method of Disposition May Data 1 Burial 2 Cremation 3 Removal from State Washington, D.C. 4X Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit Columbia Mortuary Services, P.A. 9013 Annapolis Road, Lanham, MD 20706 > Lu /M00969 Janol1 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ SEPTLCEMLA disease or condition Medical resulting in death) Examiner AZNOM USI Sequentially list conditions Examine if any liteding to immediate cause. Enter Underlying OF BREAST 'ARCENOMA Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and the burial-trar Due to (or as a consequence of resulting in death) Last physician Physician/Medical Records, P.O. Box 68760 as attending IE FEMALE 23c. If yes, outcome of pregnancy
1 __ Live Birth 2 __ Fetal death nse s 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Month Day Pregnant at time of death signed by the a 9 Unknown 23e, Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No page 2 certificate Division of Vital 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No 1 Minpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 28c. Injury at work?
1 Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 2 🗆 No Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State

Registrar DHMH 17 Rev 7/2009 29b. Signat

pplosution drive #2005,

rson who completed cause of death (Item 23a) (Type, Print)

22335

0067588

29d. Date signed (Month, Day, Year)

Reptueton Part

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 11:30AM Angelina P. Cannuli 05 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Elkton Care and Rehabiliation Center E1kton Cecil Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 M 2 XF Months Davs Hours Min. 07704/1918 Director 92 163-07-0659 PAUsual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2X No Ceci1 Elkton MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA One Price Drive 21921 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. þ 1 K Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Packer Clothing Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Antonio Cannuli Josephine Triconi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James J. Cannuli / brother 115 Caladium Lane, Newark, DE 19711 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cross Cemetery 05/14/2011 Yeadon, PA 21. Signature of Funeral Service 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 259 East Main Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between shock, or heart failu Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) years Medical Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or iinjury Due to for da the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 F FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Month Year 1 Yes 2 9 Unknown been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s page performed' this certificate 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 ☑ No ပ္ Other: To the recommend to the fundamental of the fundamental of the fundamental of the fundamental differential dif 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

29b. Signature and title

31. Date filed (Mor

30. Name and address of pe

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Registrar

npleted cause of death (Item 23a) (Type, Print)

, E

MD

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number 20023322

ERECON MD24321

5.11.2011.

AMEND#18 per FH State of Maryland / Department of Health and Mental Hygiene State 5/9/2011 AAO HEALTH DEPT. ON Confidence of Con Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Melvin E. Contee May 20 1°1 2215 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Annapolis Anne Arundel Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**∏** M 2 □ F Davs Hours Min Dec 26 ear 940 Mary land Director 215-40-8683 70 Usual Residence of Decedent show 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director Maryland Anne Arundel Odenton 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1245 Collins Ave 21113 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 Married Completed by Page 1 and 2 should be filed within 72 hours after Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced If Yes, Give Specify: Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry Red Dove (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) 12th College (1-4 or 5+) Truck Driver Trucking Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Richard Contee Lucinda S Chisley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Minion N. Contee(Wife) 1245 Collins Ave Odenton, Md. 21113 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or oth 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗀 Cremation 3 🗆 Removal from State cemetery crematory or other place)
Ston Cemetery
Zion Cemetery 4 ☐ Donation 5 ☐ Other (Specify) May 10 2011 Odenton, Md. 21. Signature of Funeral Service Licenses Name and Address of Facility

M. Reese & sons Mortuary, P.A. 22. Nam Wm . 821 Xavoy West Annapolis, Maryland 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final melastates Onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Litter Underlying Cause (Disease or linjury Due to (or as a consequence of): as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical death certificate be Box 68760 IF FEMALE JSe S 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year signed by the a 1 Yes 2 9 Unknown 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA after death. Director: After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural iniury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5330 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ste 210 Annapolis 31. Date filed (Month, Day, Year) MAY 0 9 2011 State parked Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May Physician/ 14 g 2011 6:39 a M Robert N. Canter Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore City Joseph Richey Hospice Baltimore 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Days Min (Month, Day, Year) 07/04/1958 Washington, 217-78-4711 52 Yrs. **Director** Usual Residence of Decedent show 10d. Inside City Limits or 28a-f shov notified at 10b. County 10c. City, Town or Location 10a. State Director 1 Tes 2 X No St. Mary's Ridge Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ь permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be U S A Funeral 20680 13383 Point Lookout Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, 11 Marital Status Black, White, etc. Armed Forces δ 1 X Never Married 2 Married 1 Yes If Yes, Give 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Seafood Waterman Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Miller Judith Theresa Canter J. Halvor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 49421 Airedele Road, Ridge, Maryland 20680 Kevin P. Alexander/Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Alexandria, VA 05/17/2011 4 Donation 5 Other (Specify) Metropolitan Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, Maryland 20650 21. Signature of Funeral Service License lardine 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final alcoholic Due to (or as a consellence of) Physician/ nkrown disease or condition resulting in death) Medical **Examiner** Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 687 been signed by the attending p should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Gashoin leating 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page 1 🗌 Yes 2 🗌 No Yes 2 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Division of Vital Be Other: 4 Nursing Home 5 Residence Hospice 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certificate: 1 Natural 5 Pending 1 Yes 2 No Investigation
6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practioner: To the best of my improved ge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 — Certifying Nurse Practioner: To the best of my death occurred at the time, date and place, and due to the cause(s) and manner stated 3 — Certifying Nurse Practioner: To the best of my monday, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Certifying Nurse Practioner: To the best of my Impiliedge, desti-Unity Unio 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Karhavine Hausen DeD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 828 N. SUTON ST. Ballo MD. 21201 Richer

State Registrar

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cher

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY 17, 2011 WILMA ELIZABETH CANALINI 1:15P Medical Town, or Location of Death CLINTON 4a. Facility Name (if not institution, give street and number, 4b. City. 4c. County of Death Examiner SOUTHERN MD. HOSPITAL CENTER GEORGES Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 577-44-6942 1 □ M 2**X**□ F 86 Months Hours 2 Mo2th Day 1 1925 GERMANY Director Usual Residence of Decedent 10a. State 10d. Inside City Limits 10c. City, Town or Location the Maryland Director INDIAN HEAD MD. CHARLES 1 🗆 Yes 2 🔀 No 28a-f 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? pe ms 23a omnust be Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a 20640 U.S.A. 7535 CHICAMUXEN ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2X Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 SpecifyWHITE If Yes, Give 1 ☐ Yes 2 ☐XNo Specify: 3 Widowed 4 Divorced Year or Dates item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname, GERTRUDE FRIEHOFF ပ္ HUGO WERNERY 19a. Informant's Name/Relationship (Type, Print) Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code)
CHICAMUXEN RD. INDIAN HEAD, MD. 20640 LEONARD CANALINI-SPOUSE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or oth Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State METROPOLITAN CREMATORY 5-20-11 4 ☐ Donation 5 ☐ Other (Specify) ALEX., VA. 21. Signature of Juneral Service Licenses M00479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications wat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Oneummia Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 You Pregnant at time of death 5 Other (specify) Month Day Year ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ils certificate has been signed I director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 2 No မ 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 1 🔀 Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Peactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) - aum > D35206 MAY 18.2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fut washington unny land

State Registrar 31. Date filed (Month, Day, Year)

TANNOR am 11701 Livingston Rome

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AGNES ELIZABETH CARNEY MAY 18, 2011 3:50A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 22 MATTAWOMAN COURT INDIAN HEAD CHARLES Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 XF Months 4-3-1944 Min. 144-36-8170 67 NEW JERSEY **Director** Usual Residence of Decedent 28a-f show 10b. County 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. if them 27 is marked other than "natural", or items 23a or 28a-f shorother traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD. CHARLES INDIAN HEAD 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 22 MATTAWOMAN COURT 20640 U.S.A. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: SpecifyWHITE Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o LESTER LAMOUNT CUFF MARION ELIZABETH MINK 19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19c. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
GOULDTOWN MEM.PARK 5-25-11 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State GOULDTOWN, N.J. 4 ☐ Donation 5 ☐ Other (Specify) M00479 21. Signature of Fund al Service Licensee 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Merine Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 menths?
1 Yes 2 No
9 Unknown Month Pregnant at time of death Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 1 Yes 2 No 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 Yes 2 No 2 Accident
3 Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, it may opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 10 cm MAY 18, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jonathan A- Cosin 20010 116 Irving ST NW Witshington, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dauis Physician/ Month 120 May 15, 10:05 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Genesis Elder Care Center Waldorf Charles 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Yarch 23 1 □ M 2 і XIF Months Days Hours Min 577-26-4702 **Director** Washington, DC <u>March</u> Usual Residence of Decedent show or than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits Maryland St. Mary's Charlotte Hall 1 🗌 Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29630 Three Notch Rd. 20622 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White Specify: Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker At home traumatic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Herbert Agnes Kennedy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann May/Daughter Box 70. Charlotte Hall MD 20622 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Mav Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Queen of Peace 19, 2011 4 Domation 5 Other (Specify) Helen, MD Sig are of Funeral Service Licens 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., MO0817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): brillation Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hnow mia attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day Month Year signed by the sid be detached t 9 Unknown 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed ension Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No 2 Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No Investigation filled in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide 24 hours after Funeral Direc determined edical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 71190 10. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSJIN VOLZ her Print)

Washington Annapolis, mD

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day, Year)

in Colony Pornei A.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Day 4 Monta y 8:45Pm Draine Mason Cheryl **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number)
1900 Billings Avenue **Examiner** Prince George Capitol Heights If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 4 7 Yrs. 5. Social Security Number 6. Sex **Funeral** 577-94-2821 10M 2DE Months Days Yrs. March 10,1964 WDC Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 28a-f show 7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Medical Examinar must be rediffed at 1 X Yes 2 □ No Capitol Heights PG MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20743 1900 Billings Avenue Pages 1 and 2 should be filed within 72 hours after death nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "naturel", or Items 23. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ 💢 💢 If Yes, Give Year or Dates: 1 Never Married XXMarried Black 1 ☐ Yes 2√ Xo Specify. Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Social Services Counselor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mae Benson Mason Athie Gary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co207419a. Informant's Name/Relationship (Type, Print)/W1111am Draine/Husband 1900 Billings Avenue, District Hgts, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ permit. Page Department of Important: If any Injury or once. Brentwood, MD 5-12-11 ` 4 Donation 5 ☐ Other (Specify) Lincoln WDC 20011 21. Signaty of Funeral Service Licensee 22. Name and Address of Facility House of Williams-814 Upshur St NW Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Liver Failure **Physician** /Medical Due to (or as a consequence of): Breast concer y cas Examiner Metastanc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medlcal IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2⊠No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ♣ Residence 6 ☐ Other (Specify) 2 1 ☐ Yes 2 😰 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After t Certification: Injury 1 🗖 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Diractor: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 | Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 5/10/11 MD 035950 Even such 30. Name and address of person who completed cause of death (Item 23a) (Type, Print). washington De 20010 32. Registra's Signature 31. Date filed (Month, Day, Year) State MAY 1 0 2011

DHMH 17 Rev 1/2001

Registrar

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		For State Registrar 1. Decedent's Name (First, Middle, Last)	State of Maryla		artment of F tificate of D	100	Reg. 1	ZUII	16717	
Physicia Medic		Ellen Dory				N	мау	^{Day} 7 2 ^{Year} 1		
Examin Funeral Director		4a. Facility Name (if not institution, give str Montgomery Gene 5. Social Security Number 6. Sex 1 579-68-8592		Location of Death If Under 24 Hrs. 8, Da	4	Cou				
	tor	Usual Residence of Decedent 10a. State 10b. County		City, Town or Loc	cation			4.7 Wa.	10d. Inside City Limits	
a or 28a-1 be notifie	al Director	MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 1							1 X Yes 2 No	
if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	d by Funeral	16005 Narrows Ter. 11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates,				spanic Origin? (Specify Yo n, Mexican, Puerto Rican, Specify:	USA 14. Race - Amer Black, White Specify:Blace	, etc.		
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fental Hygiene. Irked other that tic event, the N	as l	17. Father's Name (First, Middle, Last) Othello Washing	ton	CES	Branch	Govt n Surname)				
Department of Health and Mental Himportant: If item 27 is marked ott any injury or other traumatic even once.	- 8	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew Dory, Husband 16005 Narrows Ter. Silver Sprong, MD 2								
intment of H ortant: If ite njury or otl		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Red 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	iverdal	natory or other place	5/11/2		Location - City or Tiverdale		
Depart Impor any in		21. Signature of Funeral Service Licensee	as trustions ?	phenso) B	ianchi	F. S. 814		r St.NW	20011 Wash. DC	
Medical xaminer transit the burial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Onset and Death Onset and Death Onset and Death Onset and Death								
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gnec oe de	by	Part II. Other significant conditions cont	ributing to death but not	resulting in the ur	nderlying cause giv	en in Part I. 2			the cause of death?	
cate has	Completed	25. Was case referred to medical			00 51	1	24a. Was an autopsy performed?	prior to c	opsy findings available ompletion of cause of 2 No	
is certific director,	To Be	everniner?	spital:	ER/Outpatien	Othe	r: 4 Nursing Home 5		6 ☐ Other (Specia	fy)	
after death. Director: After this certificate has been signed by the attending physi in by the funeral director, page 2 should be detached for use as the t	Certificate: 1	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work M 1 □	at 28d. D ? Yes 2 \(\sum \) No	escribe how inj	ury occurred		
within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral		4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	ecify)		°	ity or Town, Sta			
within 24 hours at To the Funeral D completed filled in	Medical		r: On the basis of examina	ation and/or investi	igation, in my opinio	date and place, and due n, death occurred at the tire time, date and place, and	ne, date and pla	ce, and due to the c	ause(s) and manner state	
within To the comp		29b. Signature and title of certifier			29c. License		29d. [Date signed (Month,	Day, Year)	
10		30. Name and address of person who con	npleted cause of death (If	tem 23a) (Type, Pi Bill Prm	rint) (ce Philip	brive, dhe				
Stat	te	31. Date filed (Month, Day Year)	32. Registrar's Sig	gnature						

11-03304	
Yabeth Dade	

	of Maryland / Depa	adelible Ink. Ensure artment of Health and rtificate of Death	2011	16718
strar ecedent's Name (First, Middle,Last		B. Dade	Reg. No. 2. Date of Death Month Day Year May 1, 2011	3. Time of Death 0515 hrs

	1- For State Registrar	Cer	tificate of Deat	th	Reg. No	0.	
Physician Jedical Examine	Decedent's Name (First, Middle,t	ast) Valeth F	3. Dade	_	2. Date of Death Month Day May 1, 2011		3. Time of Death 0515 hrs
	4a. Facility Name (if not institution, I-68,1/4 mile east of Am			Town, or Location of Deat tsville	th I	4c. County of Death Garrett	
Funeral Director	227 95 3806 1	Sex 7. Age (In yrs. la	st birthday) If Und Month	ler 1 Year If Under 24Hr ns Days Hours Min	1 1	Foreign	hplace (State or intry) EHLO p' A
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hyghen. Tis marked other than "natural", or items 23a or 23a-f show any natic event, the Medical Examiner must be notified at once. To Re Commissed by Engaral Director	11. Marital Status 1 Never Married 2 Marr	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No ord If Yes, Give Year or Dates: College (1-4 or 5+)	If Yes, special Yes 2 16a. Decedent's Usual	ent of Hispanic Origin? (Sify Cuban, Mexican, Puerto No. Specify: Occupation (Give kind of orking life. DO NOT use re	pecify Yes or No- o Rican, etc.)	White, etc. Specify: B Kind of Business/ir	A ean Indian, Black, JACK
Baltimore, MD 21215-00; permit Pages I and 2 should be filed with poptramen of Realth and Mental Hygiene Important: Witem 37 is marked other in injury or other traumatic event, the Mec	Bekela	Brother Removal from State State	1633 State of Disposition (Na rematory or other place	S (Street and Number or evenson Ave.) me of cemetery,	L\ AI	naria, VA	Zip Code) 32304 Town, State The street
Physician Medical Examiner	23a. Part I. Enter the disease, or co failure. List only one cause on Immediate Cause (Final disease or condition resulting in death)			of dying, such as cardiac	or respiratory arrest, si	hock, or heart	Approximate Interval Between Onset and Death
ecuted and transit		b. Due to (or as a consequence of c. Due to (or as a consequence of d.					
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P.C. res that signed I be deta	5	s contributing to death but not re	sulting in the underlying	g cause given in Part I.	1 Yes 2 24a. Was an autopsy	24b. Were autoprior to co	he cause of death? ably 4 Unknown opsy findings available mpletion of cause of
of Vital Records og Physician: The law requir ther this certificate has been ineral director, page 2 should or To Re Commission	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 [
Division of Vinospira or Attending Physis or Attending Physis hours after death, uneral Director: After this y filled in by the funeral director Contribution: To Contrification: To	27 Manner of Death	May 1, 2011 ation 28e Place of Injury - At ho	0450 hrs	28c. Injury at Work? 1 Yes 2 № No 7, office building, etc.	28d. Describe how in Occupant auto f 28f. Location (Street or Town, State)	ixed object coll	
Division Bospital or Attent 24 hours after death 1 Funeral Director: stely filled in by the	29a Centitier			e time, date and place, an	I-68 1/4 mile East		

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

one) 2 Medical Example 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. May 2, 2011

30. Name and address of person who completed cause of death (Item 23a)

OCME

Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

State 31 Date filed (Month, Day, Year) istrar MAY 1 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5/9/2011 Day Physician/ 1:48 P John F. deHuarte Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 6 Crossbow Trail Berlin Worcester 5. Social Security Number If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🕱 M 2 🗆 F Hours Min. 5 M281/1923 Washington DC 87 Director 577-26-4718 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2x No MD Berlin Worcester 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral "natural", or items 23a 6 Crossbow Trail 21811 USA permit. Page 1 and 2 should be filled within 72 hours after death v Department of Health and Mentai Hygiene. Important: If item 27 is marked other than "nature" any injury or other transmission. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Completed by 1 Never Married 2 Married 1 Yes 2 No Specify. Year or Dates. Army If Yes, Give Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Map maker Defense Department Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Jose Antonio deHuarte Helen Meyers 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christina deHuarte(daughter) Crossbow Trail. Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven 5/13/2011 Silver Spring, MD of Funeral Service Lice 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a can equence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death signed by the a id be detached for Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown been signature Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an After this certificate has funeral director, page 2 autopsy Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be B examiner? မှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 27. Manner of D ath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: Natural 28d. Describe how injury occurred iniury 5 Pending 2 🗌 No Accident Investigation within 24 hours after death

To the Funeral Director: /
completed filled in by the f Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 7+1

DHMH 17 Rev 7/2009

State Registrar

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anistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AVEND#20b, 20c perfl State of Maryland / Department of Health and Mental Hygiene State 5/9/2011 AAO HEALTH DEPT. ONE 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05/01/2011 MARY EASTON 9:25 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bradford Oaks Nursing Rehab. Center Clinton Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. If Under 1 Year **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Month, Day, 1 🗆 M 2 🔽 F Days Min. Hours Maryland Director Yrs. 217-24-0756 99 911 Usual Residence of Decedent 28a-f shov or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director MarylandPrince George's Clinton 1 Tyes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7520 Surratts Rd. 20735 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: Black 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ene. Elementary/Seconday (0-12) 7th College (1-4 or 5+) 0 n and Mental Hygier 7 is marked other t Domestic Dr. Emily Wilson permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Walter Hall Annie Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julius D. Simms (Son) 2309 Sturdee Dr. Upper Marlboro, Md 20a. Method of Disposition 20b. Place of Disposition (Name of hews UM cemetery, crematory or other place) 20c. Location - City or Town, State Ovensville, MD 1 X Burial 2 Cremation 3 Removal from State Zion UM Church 5-9-11 4 ☐ Donation 5 ☐ Other (Specify) Lothian, Md. 21. Signature of Funeral Service Licensee Williame a Reaches of Pacility Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as a consequence of) Examiner Sequentially list conditions, if any, leading to initioanate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to for us a consequence of, physician and s the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death signed by the a 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be irector, page 2 s autopsy 1 Yes 2 No ☐ Yes **Division of Vital** 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: Other 2 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending iniury work?
1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined 24 hours Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 3 . Date filed (Month, Day, State 0 9 2011

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ma 8135 AM 2011 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 6911 Glen Ridge Circle Apt A3 Glen Burnie Anne Arunde1 If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** Min. Oct 9 Months Days Hours 1933 Maryland 219305670 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10a. State 10b. County Director 1 Yes 2X No Maryland Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 6911 Glen Ridge Circle Apt A3 21061 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ▼ Yes 2 □ No If Yes, Give Year or Dates1 952-55 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Moving & Storage 0 Truck Dr<u>iver</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Phillip D. Kent Emma Jennings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ~21061Thelma V. Kent(Wife) 6911 Glen Ridge Circle Apt A3 Glen Burnie, Md 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran 5-9-11 Crownsville, Md 4 ☐ Donation 5 ☐ Other (\$pecify) Williame Reagas of Eachi Sons Mortuary, P.A. 21. Signature of Funeral Service Licenses Java 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ years disease or condition LYOULE Medical resulting in death) Examiner 64Dars 1 celsa Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury 64,000s ew en To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Scellar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IE FEMALÉ: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Yes 2 N 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ျပ 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2011 aucen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mauroso Keller

State Registrar

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31. Date filed (Month, Day, Year)

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Kawas Blue

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a per dr., g916,06/07/2011dhb Certificate of Death Reg. No. for State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}2011 Month Physician/ 9 May 8:22 P Robert F. Fitzpatrick Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** New Jersey 1 **№** M 2 🗆 F Days Hours Min 04/09/1956 Yrs. Director <u>213-72-1530</u> 55 Usual Residence of Decedent 10a. State 10b. County with the Maryland at 10c. City, Town or Location 10d. Inside City Limits rector r 28a-f s notified 1 Yes 2 No MD Columbia Howard Ö 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 9406 Book Row 21046 United States filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: 3 Divorced 4 Divorced Completed White er than "natur , the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Air Traffic Controller Transportation and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Felicia Mastromonica t. Page 1 and 2 should be trment of Health and Mer rtant: If item 27 is mark Thomas M. Fitzpatrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanette Plante Fitzpatrick/wife 9406 Book Row Columbia, Maryland 21046 Department of Health Important: If item 27 any injury or other to once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crematory 05/16/2011 Hanover, Maryland 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc 21. Signature of Funeral Service Li M00957 4112 Old Columbia Pike Ellicott City, MD 21043 unnula 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ Thymoma Thy acous disease or condition Medical resulting in death) r as a consequenc Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): requires that the death certificate be executed burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ģ 5 Other (specify) Month Day Year signed by the at the detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page 2 s autopsy performed Yes 2 certificate 2 No 1 Yes director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 705bice this 28a. Date of injury (Month, Day, Year) completed filled in by the funeral Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: A М Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Norse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 only one 29b. Signature and tle of cer 29c. License number 29d. Date signed (Month, Day, Year) 20071287

State Registrar 21204

Suite 4105, Baltimore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

N.

11-03425

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Charlene Forbes 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Day Month 0755 hrs **Medical Examiner** May 6, 2011 CHARLENE FORBES 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Prince George's Hospital Center Cheverly 9. Birthplace (State or Foreign MARY LAND Country) If Under 1 Year If Under 24Hrs. Date of Birth (MM/DD/YYYY) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Min Director 578-02-4819 1 M 2 X F JULY 25, 1979 Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits any 10a. State 1 Yes 2 No show s 23a or 28a-f show e notified at once. PRINCE GEORGE'S GLENARDEN hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3019 BRIGHTSEAT ROAD 20706 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Marital Status Was Decedent Ever in U.S. rmit. Pages I and 2 should be filed within 72 hours after death wirepartment of Health and Mental Hygiene.

portant: If item 27 is marked other than "natural", or items jury or other traumatic event, the Medical Examiner must be jury or other traumatic event, the Medical Examiner must be Armed Forces? X Never Married 2 Married 2 X No AFRICAN AMERICAN 1 Yes 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify ₹ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) STUDENT PRIVATE 2+ 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOSEPH WILLIAMS MAMIE FORBES ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPH FORBES/BROTHER 3420 DODGE PARK RD #104 LANDOVER, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, 1 Burial 2 Cremation 3 Removal from State RIVERDALE CREMATORY 5/17/11 RIVERDALE, MARYLAND 4 Donation 5 Other Specify: ignature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and List onl one cause on each line Medical Death a Subarachnoid Hemorrhage xaminer or condition resulting in death) Due to (or as a consequence of) b. Ruptured Aneurysm Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter underlying cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED 23a-b, 27, per me, g916 6-7-11 sm ttending physician a r use as the burial -X UNPENDED The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Month Day Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) gned by the atte 1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? e has been signed be 2 should be detac þ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? 1 🗸 Yes page Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital or Attending Physician: examiner? Other Nursing Home 5 Residence 6 Other this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 Could not be or Town, State) determined Homicide 29a. Certifier 1 within 24 ho

To the Function Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E May 7, 2011 Mellette 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Margarita Korell MD.

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 31. Date filed (Month, Day Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh g916 6-9-11 vt.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ April Gillard Nathaniel 12:45 P M 30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Fort Washington Nursing Home Fort Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Bizn3 **Funeral** (Month, Day, Ye 1**X** M 2 □ F Hours Yrs. Director 80 1931248-46-9993 Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director DC N/A Washington 1 Yes 2 □ No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 20001 United States 2301 11th Street, Northwest hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ò 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: Black 'natural", Completed 3 ¥ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Welder Private 11th traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic any once. Andrew Gillard Bessie Gillard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **Elessa** D. White/ Daughter 5710 Middleton Lane, Camp Springs, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 🕅 Burial 2 🗆 Cremation 3 📝 Removal from State May 9, 2011 4 ☐ Donation 5 ☐ Other (Specify) Quantico Cemetery Quantico, VA 22. Name and Address of Facility Pope Funeral Homes, P.A. Sign urs of Funeral Service M01085 an 5538 Marlboro Pike, Forestville, MD 20747 23a. Part 1. Enter the disea shock, or heart failure. se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Interval Retween Immediate Cause (Final Onset and Death sician/ Metastatic Prostate Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nSe. 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No igned by the atte be detached for Year Month Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed Respiratory Failure, feeding Dysfunction page 2 should 24b. Were autopsy findings available prior to completion of cause of Dementia autopsy performed? Yes 2 No death? certificate 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes Other: 2 🗶 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) hours after death. Ineral Director: After this the funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending work 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours Medical 1 XX Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and of investigation, in my opinion, seath secured at the discussion and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certified 29d. Date signed (Month 42955 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Edger V.

31. Date filed (Month, Day,

MAY 1 0 2011

M.D

Potter,

42017 Ft. Washington Rd., Fort Washington, MD 20744

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death James Robert Gamble 2011 May 12, 11:30 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford 805 Lafayette Street Havre de Grace If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 1 M 2 □ F Days 217-20-7055 81 08-01-1929 North Carolina Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Harkord Havre de Grace 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America 21078 805 Lafayette Street 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1948-52 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 1 Married 1 □Yes 2 💢 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PBX Installer Communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daniel Gamble Jean Hanks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Jean Gamble (wife) 1805 Lafayette Street, Havre de Grace, Maryland 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 105-17-2011 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 21. Signature of Europal Service La 22. Name and Address of Facility Zellman Funeral Home, P.A. 21078 123 S. Washington St, Havre de Grace, Maryland 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) AMYOTROPHIC LATERAL SCLEROSIS Due to (or as a consequence of): Sequentially list conditions ue to for as a presente me di cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

þ

Completed

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and by notified at once.

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar attending physician as the nse for the detached Anier uns certificate has been signed funeral director, page 2 should be det within 24 hours after death To the Funeral Director: completely filled in by

Physician/Medical

à

Be Completed

Certification: To

Medical

29b. Signature and title of certifier

Division of Vital Records, P.O. Box 68760,

COROWARY ARTE	ERY DISEASE, HYPERTENSION,	1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown				
DYSCIPIOEMIA	& DIABETES MELLITUS	24a. Was an autopsy performed? 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No				
25. Was case referred to medical examiner?	26. Place of Death ((Check only one)				
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	e 5 Residence 6 □ Other (Specify)				
27. Manner of Death 1 XT Natural 5 □ Pending 2 □ Accident investigatio	(Month, Day, Year) Injury Work?	d. Describe how injury occurred				
3 Suicide 6 Could not be determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only) 1 Certifying P 2 Medical Exa	hysician: To the best of my knowledge, death occurred at the time, date and place, an miner: On the basis of examination and/or investigation, in my opinion, death occurred	nd due to the cause(s) and manner as stated.				

29c. License number

145344

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

5/16/2011

SUREJH DHANTANI 32. Registrar's Signature 31. Date filed (Month, Day, Year)

GLECK

622 S. 4MOW

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Year Month May Physician/ Elsie Hawkins 4, 9:30 AM Medical 4a. Facility Name (if not institution, give street and number) Sligo Creek Center 4b. City, Town, or Location of Death Takoma Park 4c. County of Death Examiner Sligo Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 579-46-4678 1 🗆 M 2 🕮 F 5-27-1932 Washington, DC Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Takoma Park 1 Yes 2 □ No MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States ò er than "natural", or items 23a or the Medical Examiner must be 20912 Funeral 7525 Carroll Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Home Maker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Elsie Hayhoe Frederick Hawkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Berkeley Springs, WV 25411 3970 Pious Ridge Rd. Gary Denee (Nephew) 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Fort Lincoln Cemetery 5/10/2011 Brentwood, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licenses Laho 1 Brentwood, MD 20722 3401 Bladensburg Road hon -4 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ croscleratio Cerdio Vascular disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Disk to for as a non-section of and I-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Day Pregnant at time of death 5 Other (specify) 1 Yes 24 g Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: XX Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1X Natural 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

P.O. Records, Division of Vital Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral To the within 2 To the I

31. Date filed (Month, Day, Year) State MAY 1 0 2011 Registrar

29b. Signature and title of certifier

Tahmina K. Ahmed, MD 831 University Blvd 32. Registrar's Signature arks

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

29a. Certifier

1 🗴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 dd. Date signed (Month, Day,

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0060100

East #27

29d. Date signed (Month, Day, Year)

Silver Spring, MD 290903

5/9/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY)A GN) 40 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** Gounty of Death ONT90ME 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year If Under Min. 1 🗆 M 2 🖼 Hours Director Usual Residence of Deceder ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Ves 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20720 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 ₩idowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DQ NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cor or Fineral Sarvice 22. Name and Address of Facility mor 23a. Part 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CEMUA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) FAILURE or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year / the a 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ THINSIDI 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available s certificate has t lirector, page 2 s autopsy prior to completion of cause of ORONAR 1 Yes 2 No Yes filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 1 No ည 1 Inpatient 2 I ER/Outpatient 3 I DOA 4
Nursing Home after death. Director: After this 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 3 🗆 within 2 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2011 minu

State

Registrar

31. Date filed (Month, Day, Year)

WASHINGTON ADVENTIST HOSP., TAKOMA PARKMI)

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Sharonda Jeanne Haley State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month Da April 3, 2011 Medical Examiner 1803 hrs Sharonda J. Haley
4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Franklin Square Hospital Rosedale **Baltimore County** 5. Social Security Number If Under 24Hrs. B. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs, last birthday) If Under 1 Year **Funeral** Months Davs Hours Director Country) Mary Land 1 M 2 X F Dec. 1,1973 213-78-7118 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 23a or 28a-f show notified at once. 1 Yes 2 X No permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-f she injury or other trannatic evest, the Medical Examiner must be notfied at ance Mary.land Baltimore Essex Director 10f. Zip Code 10g. Citizen of What Country? 930 Foxcroft Lane Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married 1 Yes specify: Black 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: ≧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Compl Private Industry 12th grade CNA 17. Father's Name (First, Middle, Last) 1B.Mother's Name (First, Middle, Maiden Surname) Be Janice Louise Cunningham <u>Robert Junior Halev</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1013 Baynor Road Essex, Maryland 21221 Janice L. Cunningham/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4-12-2011 Baltimore, MD Dopation 5 Other Specify: Greenmount Cemeterv 22. Name and Address of Facility all n-arris nera. Ome 21. S' at of Funeral Service Licens 4210 Belair Road Baltimore, MD 21206 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line. Hypertensive atherosclerotic cardiovascular disease Between Onset and /Medical Immediate Cause (Final disease a and hypertrophic cardiomyopathy Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and ca AMENDED 23a, pt.II, 27, per me, g915 5-26-11 sm physician a X UNPENDED Physician/Medi Hospital or Attending Physician: The law requires that the death certificate be Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth use as t 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. é 1 Yes 2 No 3 Probably 4 Unknown Diabetes, hyperlipidemia, chronic renal failure Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 si performed? ✓ Yes 2 No death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital: 1 🗸 Inpatient 2 🔲 ER/Outpatient 3 🔲 DOA Other Nursing Home 5 Residence 6 Other: this 1 🗸 Yes 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 5 Pending 1 Yes 2 No 2 ___ Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Signature and the of certifie 29c. License number 29d. Date signed (Month. Day Year) **(**9 O.C.M.E April 4, 2011 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 MAY 25 2011 (ar) 32. Regist ar's Signature State Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:39PM Oliver William Jones Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Doctors Community Hospital Lanham Prince Georges 5. Social Security Number If Under 1 Year . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Birthpiac Country) MD **Funeral** Months 1 X M 2 □ F Hours Min. (Month, Day, Year) 1920 Director 579-18-8050 90 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Prince Georges Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10200 Diablo Avenue 20706 United States 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married X Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 Divorced Year or Dates, 1945 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Labor Foreman Federal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ William Jones Mabel Carroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mabel E. Jones/ Wife 10200 Diablo Avenue Lanham, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Lincoln Cemetery 05/10/2011 Brentwood, MD Sign June Servin 22. Name and Address of Facility Ft. Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722 23a. Part 1 Enter the disease, or co shock, or heart failure. List only mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Myocardial Infarction hr_ Medical Due to (or as a consequence of) Examiner Coronary Artery Disease 3 wks Sequentially list conditions Examine Due to (or as a nonsequence of): cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician; The law requires that the death certificate be executed Hypertension attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy In the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death the hed ed by the signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has blirector, page 2 s autopsy perforn performed? Yes 2 X No 1 ☐ Yes 2 🔀 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 X No Other: ျှ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at hin 24 hours after death.

the Funeral Director: After in pleted filled in by the funeral 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 🗌 No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D0042684 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jay Zwally 8118 Goodluck Rd. Lanham, MD 20706 31. Date filed (Month, Day, Year State n 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Physician/ Month 5 Klein Kath leen LUCY 2011 12-154M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death have el Regional PRINCE Hospital haurel GEORGE Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Ade (In vrs. last birthday) 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign 1 □ M 2 🖾 F Hours Min. 92 Saskatchewan, Canada 220-48-9674 **Director** July 16. Usual Residence of Decedent show 10a. State filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland University Park Prince George's 1 🏿 Yes 2 🗆 No 10e, Street and Number 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? Funeral 4015 Beechwood Road 20782 Canada n "natural", or item ledical Examiner n 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 🗶 No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White Completed 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene tant: If item 27 is marked other than ury or other traumatic event, the Me Elementary/Seconday (0-12) University of Maryland College (1-4 or 5+) Secretary 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Daniel Delaney Evelyn Sutherland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4015 Beechwood Road, University Park, MD 20782 Maureen M. Klein / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Important: If it any injury or o Department of 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 5/13/2011 Brentwood, Maryland Fort Lincoln Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue (5)a Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis Medical resulting in death) Examiner piration PNEU MONIG Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to for as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Year ☐ Pregnant at time of death☐ Unknown ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after deau..

To the Funeral Director: Af Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 📕 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier Karunwi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Adedeji 32. Regis State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Month **Physician** 1:10 a MAY 2011 /Medical ANDREW JAMES KUDERA 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Kent Galena 32180 Shorewood Rd. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number (In vrs. last birthday **Funeral** Months Days Hours 1**√** M 2□ F 76 Feb 8 1935 New Jersev 148-26-1326 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County show Item 27 is marked other than "natural", or items 23a or 28a-f shoil or traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Kent Galena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 32180 Shorewood Rd. 21635 U.S.A. Funeral death \ 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after Tyes 2 No 1958 Yes, Give 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 2 3 Widowed 4 Divorced Year or Dates: -1960 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Switching Manager Telephone Company 12 and Mental Hygie Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Andrew S. Kudera Mary Karaman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a 32180 Shorewood Rd. Dorothy R. Kudera (wife) Galena, MD 21635 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If Ite any injury or otl 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Old Bohemia Cemetery 5/23/11 Warwick, MD. 4 Donation 5 Other (Specify) 21. Signature of runeral Service in onsee 22. Name and Address of Facility
Galena Funeral Home of Stephen L. Schaech M00510 118 West Cross St. Galena, MD. 21636 Approximate Interval Between Onset and Death Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or us a consequence of) Examiner The law requires that the death certificate be executed ng physician ar Due to (or as a consequence of) Box 68760, Physician/Medical cate has been signed by the attending page 2 should be detached for use as IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 0 I ☐ Yes 2 ☐ No 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate 1 ☐Yes 2 No 1 ☐Yes 2 ☐ No Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 1 Yes 2 No 5 Residence 6 ☐ Other (Specify) 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day, Year) 1 Natural
2 Accident Division Injury 5 Pending investigation 1 ☐Yes 2 ☐No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and 29c. License number

State Registrar

DHMH 17 Rev 1/2001

(8. 2)

4701 Ogletown-Stanton Rd. Suite 4200 Newark, DE. 19713

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Scott W. Hall,

25 2011

31. Date filed (Month, Day,

May 20, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Richard Lessington <u>11:</u>44^A м Medical April 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 172 Green Meadow Way, Apt.#A Largo Prince George's Social Security Number 1 Year If Under 24 Hrs. Days Hours Min. . Age (In yrs. last birthday) 62 yrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days 1 🛣 M 2 🗆 F (Month, Day, Year, 092-38-9990 Yrs. Director April SCUsual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Largo 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 172 Green Meadow Way 20774 United States Apt.# 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Specify: Completed 3 Widowed 4 X Divorced Black 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 should be filed withi alth and Mental Hygiene 27 is marked other th 12th Correctional Officer Government other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) un-obtainable ပ Inel Lessington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health Helena Lessington/ Daughter 172 Green Meadow Way, Apt.#A, Largo, MD 20774 item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1. Department of I Important: If it any injury or of of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place 5/11/2011 4 Donation 5 Other (Specify) Maryland Veteran Cen. Cheltenham, MD 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 01015 5538 Marlboro Pike, Forestville, MD 20747 Part 1. Enter the disease, or competations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Approximate Interval Between Onset and Death Immediate Cause (Final Physician. Cardiomyopathy disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, It any, leading to in model cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of: that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physiclan a for use as the burial-Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Day Year signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension, Diabetes Mellitus Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy performed? Yes 2 K No death? 1 Yes 2 No Yes or Attending Physician: of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2' \No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Division Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 🖎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe D52900 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1310 Southern Ave, SE, Washington DC 20032 Dr. Musa Momoh, M.D. 31. Date filed (Month, Day, Year) State 0 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ May 10, ²2^y011 Elizabeth Lawton Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 230 Charleston Rd. Ocean Pines Worcester 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1**X** M 2 □ F Min. 6 - 2 9 ay, Year 9 1 7 187-05-4004 93 Director Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f shor Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location Director MD Worcester Ocean Pines 10e. Street and Number 10f. Zip Code Funeral 230 Charleston Rd. 21811 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status o. 1 Never Married 2 Married þ 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. marked other than "natural", Completed 3 □ Widowed 4 □ Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Assistant Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James C. Moore Anna Garret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Beverly Bigler / daughter 230 Charleston Rd., Ocean Pines, MD 21811 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of H Important: If ite any injury or ot permit. Page 1 a 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Birmingham Laf Cem. 5/21/11 West Chester, PA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Pa./ 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ DEMIENTIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner RANSIENT ISCHEMIC ATTACKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine that the death certificate be executed and-tran Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, Completed has been signed to the second 24a. Was an autopsy performed? Yes 2 No page certificate 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital: 2 No 1 🗌 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death le Hospital or Attending Pl n 24 hours after death. le Funeral Director: After the oleted filled in by the funeral 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? (Month Day, Year) 1X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 2 No 1 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29c. License number D58755 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRIVE BERUN, MD 21811 GLENN ARZADON, 9714 HEALTHWAY SH 10

10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? USA 14. Race - American Indian, white 16b. Kind of Business Industry PA News Papers 20c. Location - City or Town, State Approximate Interval Between Onset and Death >21months 23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, 29d. Date signed (Month, Day, Year) MAY 11, 2011

3. Time of Death

Birthplace (State or Foreign Country)

PA

10:23AM

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 05 201 11:15A M Douglas C. Moore Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 541 Biddle Street Chesapeake City Ceci1 Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 8. Date of Birth Funeral Hours 1 X M 2 | F 0470571934 77 Director India 210-42-6707 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No MD Ceci1 Chesapeake City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 541 Biddle Street 21915 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married ģ 2 X No ☐ Yes Maryland 21215-0036 72 hours after 1 Yes 2 X No Specify: White If Yes, Give "natural", 3 Divorced 4 Divorced Completed Year or Dates mit. Page 1 and 2 should be filed within 72 hours artment of Health and Mental Hygiene.
ortant: If item 27 is marked other than "natur injury or other traumatic event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Franklin Mint Tool and Die maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Archibald Moore Murial Dalton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 541 Biddle Street, Chesapeake City, MD 21915 Phyllis E. Moore / wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) P.A. R.T.Foard Funeral Home heral Service Licensee Rising Sun, MD per mil Der ar Imr or any in 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 259 East Main Street, Elkton, MD 21921 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Curkinsons disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Dav Pregnant at time of death the a Unknown 9 Unknown P.O. signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Sheet down Records, 1 ☐ Yes 2 Ro 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has s certificate has lirector, page 2 performed 1 ☐ Yes 2 ☐ No Yes 2 N Division of Vital 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 No ျှ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funera 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and title of certifier D0023322 Jachder-S. Mi) 5.10.2011. who completed cause of death (Item 23a) (Type, Print) 126 A, E thigh ST, Elpton MD 21921.

Registrar

State

FU MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRIL 28^{ay} 201^{Year} LENORA V. McELHANY 2:45 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE GARDENS OF WILLIAM HILL MANOR EASTON TALBOT Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 M 2 X NEW JERSEY 0670371934 76 Director 220-32-2010 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No MARYLAND TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 545 CYNWOOD DRIVE 21601 UNITED STATES . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural". If Yes, Give Specify: WHITE 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) 12 BANKING/FINANCE ASSISTANT VICE PRESIDENT and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည LEONARD VAN SCHAIK MARGARET KLAASEN ortant: If item 27 is marke injury or other traumatic and 2 should be Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GAIL M. NAGEL / DAUGHTER 8269 GANNON CIRCLE, EASTON, MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Page 1 8 permit. Page 1 a
Department of IImportant: If ite
any injury or ot Date 1 X Burial 2 Cremation 3 Removal from State WOODLAWN MEMORIAL PARK 4 Donation 5 Other (Specify)

21. Sign are of Final Service Lie MAY 3, 2011 EASTON, MD Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON ST., EASTON, MD 21601 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown has been signed to should be 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate ha death? 1 ☐ Yes 2 ☐ No 25. Was case referred to edical Be 26. Place of Death (Check only one) Hospital 잍 1 Yes 2 🗖 No 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No neral Director: A 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 - Homicide determined City or Town, State) 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month. Day. Year)

6 Registrar

DHMH 17 Rev 7/2009

State

508 IDLEWILD AVENUE, SUITE 5, EASTON, MD

21601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT B. SANCHEZ, MD

MAY 02

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 4:00 A.M M. 05 2011 05 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Crescent Cities Center Prince George's Riverdale If Under 1 Year | If Under 24 Hrs. 5. Social Security Number (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 M 2 XF 577-78-8692 **Director** <u>09/04/1958</u> Wash. D.C. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show other traumatic event, the Medical Examiner is ust be notified at Yes 2 No Director Md. P.G. Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Funeral 505 Goldleaf Avenue 20743 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired).

Board SFCShtHact Appeals Department of Elementary/Secondary (0-12) College (1-4or 5+) Veterans Affairs 1 year and Mental Hygie is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Stover Smith Addie Pearl Walker မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) t of Health a Jerry Martin/Husband 505 Goldleaf Ave., Capitol Heights, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of Important: If it any Injury or o 1 Burial 2 Cremation 3 Removal from State 05/12/11 Harmony Mem. Park Landover, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Henry S. Washington & Sons Co., Inc. 21. Signature of Funeral Service Licenses rall 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part1. Enter the disealle, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pneumonia **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underhing Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by decubitus ulcer Wo 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 🗆 No 1 □ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Mursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural after death. 1 ☐ Yes completely filled in by the 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

Box 68760.

P.0.

Division

30. Name and address of person

no completed cause of death (Item 23a) (Type, Print)

East-West

4409

D0058095

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Ameno#23e.PerPhys.PC5-17-11cr Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death May 3, Year Physician/ 2011 4:45 A^{M} Stanley B. McCoy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Southern Maryland Hospital Clinton 7. Age (In yrs. last birthday, 52 Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, May 29, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 577-86-1726 1958 **Director** Usual Residence of Decedent show. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland ms 23a or 28a-f shorms must be notified at Director Yes 2 No MD Charles County Waldorf 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code by Funeral 20603 United States 2535 Winslow Court items death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ō Specify: Black Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the Aonce. Private Construction Paving Laison Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Lawrence James McCoy Marguerite Brickhouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kathryn Young McCoy/Wife 2535 Winslow Court, Waldorf, Mary1and 20603 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition W Burial 2 Cremation 3 Removal from State 4 Donation 5 Cher (Specify) Fort Lincoln Cemetery 5/7/2011 Brentwood, Maryland 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Lice 5538 Marlboro Pike, Forestville, Maryland 20747 01083 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last (or as a consequence of) inding physician use as the buria the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Day Year Pregnant at time of death Other (specify) signed by the at d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No OF Trobably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has I autopsy performed?

1 Yes 2X No 1 🗌 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum_{\text{Nursing Home}} \) 5 \(\sum_{\text{Residence}} \) 6 \(\sum_{\text{Other}} \) Other (Specify) 1 Yes 2 X No 1 🗶 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA မ 28a. Date of injury (Month, Day, Year) funeral 28c. Injury at Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No injury X Natural 5 Pending n 24 hours after death.

e Funeral Director: Al Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29d. Date signed (Month, Day, Year) 005 321 mum D

State Registrar 30. Name and address of

person who completed cause of death (Item 23a) (Type, Pen

		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
	-	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2011 6740
Physici Med		1. Decedent's Name (First, Middle, Last) Henry Sturgis Morgan, Jr. 2. Date of Death Month Day 6 2011 10:06 AM
Exami		4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Center 4b. City, Town, or Location of Death Annapolis 4c. County of Death Anne Arundel
Funera Director		5. Social Security Number 045-32-3635 6. Sex 1
Aaryland Ba-f show tified at	rector	Usual Residence of Decedent 10a. State Maryland Anne Arundel 10c. City, Town or Location Annapolis 10d. Inside City Limits 1 🛛 Yes 2 🗆 No
with the A 23a or 2 ust be no	Funeral Director	10e. Street and Number 6 Louden Lane 10f. Zip Code 21401 10g. Citizen of What Country? U.S.A.
ire, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2XXMarried 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2XXMarried 1 Never Married 2 No If Yes, Give 1944–75 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes, Give 1944–75
215-C in 72 hou e. han "natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)
nd 212 filed within at Hygiene. d other than	Be	Admiral U.S. Navy 17. Father's Name (First, Middle, Last) Henry Sturgis Morgan 18. Mother's Name (First, Middle, Maiden Sumame) Catherine Adams
Maryland 21215-0036 12 should be filed within 72 hours after alth and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam	10	19a. Informant's Name/Relationship (Type, Print) Alexandra McCain Morgan/wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Louden Lane Annapolis, Maryland 21401
Baltimore, Maperait. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tran once.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other once.		Arlington Nat. Cemetery Unknown Arlington, Virginia 21. Signatura Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home
B F F F F F F F F F F F F F F F F F F F	18	Jodd & Niller 147 Duke of Gloucester St., Annapolis, MD 21401
← °h, sician } Medica		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Print (1000 - 2000 - 2000 - 2000)
Examine		Due to (of as a consentrence of).
executed an and ial-transit	Examiner	Sequentially list conditions, if any lee ling to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):
60 ate be exe	70	d
ords, P.O. Box 68760 v requires that the death certificate be executed to been signed by the attending physician and should be detached for use as the burial-transit	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown Unknown 23c. If yes, outcome of pregnancy 23d. Date of delivery 23d. Date of delivery Month Day Year Ye
s, P.O. res that the signed by t	d by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	omplete	24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No
al H an: Th an: Th trifficat	Be C	25. Was case referred to medical 26. Place of Death (Check only one)
Vita hysici nis cen I direc	일	exeminer? Hospital: Hospital: DCA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
on of ending Pl sath. or: After the	Certificate: To	27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury a work? 2 Accident Investigation 28d. Date of injury M 1 Yes 2 No
Divisi tal or Atter rs after de al Directo		3 Suicide 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Division of Vital Recc To the Hospital or Attending Physician: The law Within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 is	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
S S S S S S S S S S S S S S S S S S S		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5 /6 / 1
2571		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) However In Ho
St Regist	ate rar	31. Date filed (Mort AY YO) 9 2011 32 Segistrar's Signature & Sand

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death May 14, Physician/ 20°11 3:30 P Geoffrey Ronald O'Keefe Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** St. Mary's Charlotte Hall Charlotte Hall Veterans 9. Birthplace (State or Foreign 6. Sex 1X M 2 □ F 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Year) 1923 England Oct. 28, Director 065-18-8281 87 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 72 hours after death with the Maryland Director Galesville 1 Tyes 2 No Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 4877 Anchors Way 20765 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🖾 No Specify: Specify 3

Widowed 4 □ Divorced Year or Dates and Mental Hygiene.
is marked other than "natur aumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important. If item 27 is marked other than any injury or other traumatic event, the M Elementary/Seconday (0-12) Sales Manager Glass Company Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maisie Woodcock Joseph O'Keefe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anchors Way, Galesville, MD 20765 4877 Nancy Dunlap/Daugther 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May 16, 1 Burial 2 X Cremation 3 Removal from State Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols F.H., P.A., Brinsfield-Echols Crem 22. Name and Address of Facility g a re of Funeral Service Licensee 30195 Three Notch Rd., Charlotte Hall, MD 20622 M00817 23a. Part 1. Enfer the disease, or complications that caused shock, or heart failure. List only one cause on each line ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CARDIAC Medical Due to (or as a consequence of): Examiner NGESTIV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) g physician and is the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed SSENTIA Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown been signed by the should be detached g 🔲 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DISEASE PARKINSON 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours are deatl To the Funeral Director completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certil MD D0067788 5,16.2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar LEENA

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

gistrar's Signature

Charlotte Hall, MD 20622

RAO KODALI

MAY 19 2011

				Please Ty	pe or Print in Black Amend 206 per State of Maryland /	ck Indelible Ind	Finshire All (Copies Are	e Legible.	
				For State Registrar	state of Maryland /	Certificate of D		Reg. N	2011	16742
		Physicia		1. Decedent's Name (First, Middle, Last)	Porter	50		Date of Death Month, Da	3y - 2011	3. Time of Death
1	ر ار	Medic Examin		4a. Facility Name of not institution, give stree	t and number)	4b. City, Town, or	Location of Death		c. County of Death	1 /
	*	Funeral		70 Woods Way 5. Social Security Number 6. Sexy	7. Age (In yrs. last bir	thday) If Under 1 Year Months Days	If Under 24 Hrs. 8. I Hours Min. (Date of Birth	9. Birth	nplace (State or Foreign
		Director		215-46-2150 1 1 JM Usual Residence of Decedent	^{2□F} 43	Yrs. Worth's Days	Hours Will.	Month, Day, Year) 5-16-194	7 Wash	ington, D.C.
		iryland t-f shov ied at	ctor	10a. State 10b. County	10c. City, Tow					10d. Inside City Limits 1 Yes 2 No
		the Ma a or 28a be notif	Funeral Director	10e. Street and Number		Kton 10f. Zip Code		10g. C	itizen of What Cou	
		ath with	unera	70 Woods Way	Was Decedent Ever in U.S.		921 spanic Origin? (Specify '	Yes or No-	USA 14. Race - Ameri	can Indian.
	36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No If Yes, Give	13. Was Decedent of Hill If Yes, specify Cubar	n, Mexican, Puerto Ricar Specify:	n, etc.)	Black, White	
	2-00		Completed	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educat (Specify only highest grade co	Year or Dates.	Decedent's Usual Occupa (Give kind of work done d	ation	16b. i	Kind of Business I	ndustry
	121	/ithin 72 iene. r than the the Me	Com		College (1-4 or 5+)	life. DO NOT use retired)	W Working		Printin	19
	Maryland 21215-0036	should be filed within 72 n and Mental Hygiene. 7 is marked other than " raumatic event, the Mec	To Be	17. Father's Name (First, Middle, Last)			18. Mother's Name (Fin	st, Middle, Maiden	Surname)	
	aryla	hould by and Mer s marke umatic		19a. Informant's Name/Relationship (Type, F	Print) 191	o. Mailing Address (Street a	Raybay and Number or Rural Rou	Ite Number, City o	or Town, State, Zip	Code)
		1 and 2 sh of Health a item 27 is other trau		Connie Porte 20a. Method of Disposition	r/wife 7	o Woods of Disposition (Name of	way Date	EIKto	M MO_ Location - City or -	21921
	Baltimore,	o 0 = =		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)		ery, crematory or other place	e) , ! U	2011 Ne		DE
	Balti	permit. Page Department Important: any injury o		21. Signature of Edneral Service Licens			s of Facility Fami	1. Finer		12702
				23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one ca		not enter the mode of dying	g, such as cardiac or res		Car Z, o	Approximate Interval Between
1		hysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	Acute/Ch	Sonic K	esporta	torg to	culus.	Onset and Death
rgu		Examiner	<u>.</u>	Sequentially list conditions, b. =	Emphys	ener/(000	-(many year
		rted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c		Zoynappro				
		e execucian and	l= 1	resulting in death) Last	Due to (or as a consequence	of):				
	8760	certificate be nding physici use as the bu	Medic	d						
	Box 68760	v requires that the death certificate be executed to been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medica	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death	h 3 Ectopic pregnanc 5 Other (specify)	у		23d. Date of deli Month	very Day Year
	P.O. B	The law requires that the death ate has been signed by the atte page 2 should be detached for	Physi	9 Unknown	9 Unknown		en in Best I	00 01444	4.71	the of was of death?
	s, P.	uires than signed Id be de		Part II. Other significant conditions contrib	mal Zi	millate underlying cause giv	en in Part I.			the cause of death?
	Records,	≥ 8 0	Completed by	Curanic 1	Conjest	veheor	+ Failu	24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
in	l Re	sician: The law r certificate has b lirector, page 2 s		25. Was case referred to medical	1		ace of Death (Check only	performed? 1 Yes 2 4	death?	2 🗆 No
ma	Vital	hysicia this cert al direct	To Be	examiner? 1 Yes 2 No	1 Inpatient 2 ER/O	utpatient 3 DOA Othe	er: 4 🗌 Nursing Home	5 Residence		fy)
5	on of	Attending Physician: or death. ector: After this certific by the funeral director,	icate	1 Natural 5 Pending 2 Accident Investigation		Time of 28c. Injury work M 1 □	y at ? Yes 2 □ No	Describe how inju	iry occurred	
	.≥	i graffe	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, for building, etc. (Specify)	arm, street, factory, office		Location (Street a City or Town, State	nd Number or Run e)	al Route Number,
300		Hospital 24 hours Funeral I	Medical	(Check 2 Medical Examiner:	n: To the best of my knowledge, On the basis of examination and/	or investigation, in my opinio	n, death occurred at the t	time, date and plac	e, and due to the c	ause(s) and manner stated.
H		To the I within 2 To the I comple	Ĕ	only one) 3 Certifying Nurse Pr 29b. Signature and title of certifier	actioner: To the best of my knov	vledge, death occurred at the 29c. License			e(s) and manner as attention and manner as	
1				Jagenti	lead of the Ottom State	Tura Drian	230)	09	5/11/2	0//
		3		JAYANTILA.	leted cause of death litem 23a)	EL 123512	gerly Are	-1811	cton	4)21921
		Sta	te	31. Date filed (Month) 2 2011	32. Registrar's Signature	arke	J	/		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year May 3, 2011 Physician/ 14:17 PM Francis Joseph Proctor Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Southern Maryland Hospital Clinton Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** 1 **X** M 2 □ F Months Davs Hours 05-28-1939 578-52-0777 DC Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location aţ Page 1 and 2 should be filed within 72 hours after death with the Maryland Director must be notified 28a-f 1X Yes 2 □ No Prince George's District Heights MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 Funeral 23a United States 20747 2132 County Road Apt.#101 items ? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 0 δ 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify Specify: "natural", 3 Widowed 4 Divorced Black. Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: I item 27 is marked other than 1 any hipury or other traumatic event, the Me once. College (1-4 or 5+) Elementary/Seconday (0-12) Private 10th Groundsman Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Della Helen Tyler Horace James Proctor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18345 Williams Rd., Triangle, VA 22172 Grace May /Sister 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date ■ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, May 13, 2011Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specific Resurrection Cen. 22. Name and Address of Facility Pope Funeral Homes, P.A. Signature of Funeral Service 5538 Marlboro Pike, Forestville, MD 20747 Ture M01085 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) e to (or as a consequence of) Examiner ETASTATI Sequentially list condition Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 Unknown ed by t s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed cate has Yes 1 TYes certific 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at After Natural 5 Pending 1 Yes 2 No ithin 24 hours after death.

the Funeral Director: Ai
ompleted filled in by the fu Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2

To the I

compler only one 29d. Date signed (Month, Day, Year) 29b. Signatur m 23a) (Type, Print) CHNTON

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 6, 20 Pay Year Physician/ 11:35 Alfred William Paquette Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 16 Maryland Ave Annapolis If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**x** M 2 □ F Hours 02971371918 Mfffffesota 93 565-12-0285 Director Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County filed within 72 hours after death with the Maryland Director ¥∏ Yes 2 ☐ No Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21401 USA 16 Maryland Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2X No Black, White, etc. 1 Never Married 2 X Married Completed by Maryland 21215-0036 White 1 ☐ Yes 2X No Specify. If Yes, Give 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Owner/Operator Elementary/Seconday (0-12) College (1-4 or 5+) Clothing 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Mary Kloempken Alfred Paul Paquette 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16 Maryland Ave. Annapolis, MD 21401 Janice Krauss Daughter Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Atlantic Crematory 05/07/2011 Glen Burnie, MD . Signature of Fane A Service Licen 22. Name and Address of Facility 12 Ridgely Ave Annapolis, MD 21401 Hardesty Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ₹nysician/ 0405 Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed use as the burial-transit attending physician and that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? po Month Day Year Pregnant at time of death 2 🗌 No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 2 🗆 No this certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and MD 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rederive mo 139 Karkowsky 31. Date filed (Month, Day, Year) Registrar's Signature State

Registrar

MAY 0 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Bette Jewell Phillippi 11:30A^M 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 59 Beacon Hill Ocean Pines Worcester 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Hours Min. 1 M 2 XF 76 228-42-9839 Yrs. Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 Yes 2 X No MD Worcester Ocean Pines 10e. Street and Number 10g. Citizen of What Country? Funeral 59 Beacon Hill 21811 USA be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner o. 1 Never Married 2 Married þ 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced white Year or Dates 27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Administrative Assistant Dept. of Defense Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lawrence Miller Phillippi Gertrude Blevins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Iris Lane, Montclair, VA 22025 Bryan A. Dixon / 15311 item 2 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Date Important: If its any injury or of once. 1 Burial 2 K Cremation 3 Removal from State 5 Other (Specify) First State Crem. 5/10/11 4 Donation Millsboro, DE 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Se vice Licensee 108 William St., Berlin, MD 21811 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or treat failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Myocardial Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of): Physician/Medical 68760 use as 1 IE EEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No Yes the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital the funeral director, Be 26. Place of Death (Check only one) 1 Yes Other: မ 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniurv work? 1 ☐ Yes 2 ☐ No s after death. I Director: Aft Accident Investigation Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical (29a. Certifier 1 Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier May (0, 2011 30. Name and address person who completed cause of death (Item 23a) (Type, Print) Berlin, MD 21811 Raichack MUMA (1107 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death May 14, Physician/ 2ŎĨ1 1:48 p.m. Winifred Josephine Rudman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospice House of St. Mary's Callaway 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 🗆 M 2 🛛 F Months Days Hours Min. (Month, Day, Yea 05/12/192 Country)
Illinois **Director** 333-12-8317 88 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location notified at Director 1 X Yes 2 No Maryland St. Mary's Leonardtown 10f. Zip Code 10g. Citizen of What Country? ò 10e, Street and Number must be 23a Funeral United States 22680 Cedar Lane Court 20650 items death v Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Examiner Armed Forces?

1 Yes 2 No Ь 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: "natural", 3 X Widowed 4 ☐ Divorced White Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 72 I Hygiene. within 7 Elementary/Seconday (0-12) College (1-4 or 5+) Sewing Seamstress 12 other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be filed and Mental H ၉ permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or com-Clara Irmen John T. Lein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40880 Cooper Drive, Leonardtown, MD 20650 Albert Rudman/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols Cre 05/18/2011 Charlotte Hall, MD 21. Signature of Program Service Assee

Edward N. Brinsfield 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00052 22955 Hollywood Road, Leoanrdtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ INOUND B disease or condition Medical resulting in death) ce metatotic Concer Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying now mernery Examine -transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) burial attending physician for use as the buria Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d Date of delivery 3 Ectopic pregnancy in the past 12 month Month 5 Other (specify) Pregnant at time of death been signed by the should be detached Unknown but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform this certificate 1 Yes Yes 2 L To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) House Hospital: 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury atural 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and t

State Registrar address of person

of death (Item 232) (Type, Print)

Three NotaH

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State	Pleas			and / De	partment of beartificate of L	lealth and N	Mental Hy	giene _,	2011	1671.7	
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Funeral Director		5. Social Security No. 238–86–75	umber	S. Sex		rs. last birthda Yrs.	y) If Under 1 Year Months Days		8. Date of Birt Aug . 30,	h	g. Birthp	ace (State or Foreign	
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ter c	و ک	3116 A1at 11. Marital Status 1 Never Marri	ied 2X Marri	12. Was De	ecedent Ever in Forces? es 2 No Give	1 U.S. 1	3. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	1	14. Race - American Indian, Black, White, etc.		
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Page 1 ar ment of He ant: If iter ury or oth				3 ☐ Removal fr pec <i>ify)</i>	om State	cemetery, c	sposition (Name of crematory or other place ncoln Ceme	tery 5/13		Bren	cation - City or To	D	
permit. Departe Import any inj		21. Signature of For	neral Service Li	censee			22. Name and Addre 3401 Blad				uneral H wood, MD		
60 ⊭ ÷ 1.	cal Examiner	shock, or hea Immediate Cause (disease or conditic resulting in death) Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated event resulting in death)	rt failure. List or (Final on anditions, nmediate rlying iinjury s	a. Met Due b. Set Due c. Due	each line.	in-res: sequence of): sequence of):	istant Sta				w/ bacte	Approximate Interval Between Onset and Death	
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the bur	Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1	outcome of prove Birth 2 regnant at time	Fetal death	3 ☐ Ectopic pregnands ☐ Other (specify) _	су		2	23d. Date of delive Month	ery Day Year	
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the Hospi nin 24 hou the Funer npleted fil	Medical	(Check 2 only one) 3	2 ☐ Medical E	caminer: On the Nurse Praction	basis of examir	nation and/or in	ge, death occurred at the	on, death occurred and pla	at the time, date a	and place, ne cause(s)	, and due to the cal s) and manner as st	ated.	
North Con		29b. Signature and	title of certifier	1	Λ	10	29c. Licens D 52				• 2011	Jay, Year)	
3		30. Name and addr Sheilesh	Sheth,	MD 15	00 For	est G1	en Rd. Si	lver Spri	ing, MD	2091	0		
State		31. Date filed (Mont	th, Day Year) N 2011	Person 32	Registra s S	igna re	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2011 PM 1839 Mau Shirley G. Schroeder Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Harkord Air If Under If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/26/1924 9. Birthplace (State or Foreign Country)
Maryland Social Security Number 7. Age (In vrs. last birthdav) 1 Year Funeral 1 □ M 2 👿 F Months Days Hours Min. Director 220-12-8472 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location aţ 10d. Inside City Limits Director must be notified 1 Yes 2 No Havre de Grace Harkord 10g. Citizen of What Country? 0 10e. Street and Number items 23a Funeral U.S.A. 110 South Washington Street 21078 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 10 þ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White 3 ₩ Widowed 4 □ Divorced Specify "natural" Completed Baltimore, Maryland 21215-00 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hyglene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Emma Marie Connelly John J. Benton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tra Gwendolyn Ashby (Daughter 20a. Method of Disposition Washington Street, Hayre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Loudon Park Cemetery! 05/19/2011 Funeral Service Licensee Zellman Funeral Home, P.A. Washington St., Havre de Grace Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cease on each line. Immediate Cause (Final Onset and Death Physician/ ocarle disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of, Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical as IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 2 🗌 No 1 Yes 25. Was case referred to medical Hospital or Attending Physician: 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending work? 2 🗌 No Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated for this ingredience. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated for this cause (s) and manner stated fo (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chesapeake State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2<u>011</u> 12 3:26 p.mM Jane Margaret Tylosky May Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Callaway Hospice House of St. Mary's 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗓 F Months Days Hours Min. 10/29/192 89 **Director** Pennsylvania 178**-**12**-**5075 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10a. State 10d. Inside City Limits Director 1 🗌 Yes 2 😾 No Mayland St. Mary' Leonardtown 10f. Zip Code 10e. Street and Number ō 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 23018 Hopton Lane <u>States</u> United 13. Was Decedent of Hispanic Drigin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 11, Marital Status Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Year or Dates Specify: 3 M Widowed 4 Divorced Completed White 16a. Decedent's Usual Dccupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Motel Owner n and Mental Hygien is marked other t Mote1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Michael Rubel Mary Wergot 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Rossi/Daughter <u>3018 Hopton Lane, Leonardtown, MD 20650</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Francis Xavier Cem 05/21/2011 Leonardtown, Maryland Sign and ral Service Edward N. Brinsfield, Jr. Brinsfield Funeral Home, P.A. M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consiquence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or impury that initiated events resulting in death) Last the burial-tran and Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No for 5 Other (specify) Month Day Year Pregnant at time of death signed by the al d be detached fo Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy this certificate 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 X Other (Specify) House Hospital: Other: 은 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death funeral 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred After Natural 5 Pending injury s after death. 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier 🔎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

24 hours a within 2. To the F

> State Registrar

completed

(Check

only one 29b. Signature and title of certification

Avani D.

Shah,

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

47066

29d. Date signed (Month, Day, Year)

13

29c. License number

22650 Cedar Lane Court, Leonardtown, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For State Registrar	State o	f Marylan		artment of H rtificate of L			F	Reg. No.	We work as	16750	
	Physicia	an	Decedent's Name (First, Middle	e, Last)						2. Date of Dea May	ath 6,2011	Yeer	3. Time of Death 6 pm M	
1	/Medic	al	Janet Mari 4a. Facility Name (If not institution				4b. City, Town, or	Location	of Death			nty of Death	<u> </u>	
	Examin	er	Fairfield Nurs									Arun	_	
	Funeral		5. Social Security Number	last birthday)	If Under 1 Year	If Under		8. Date of Birtl (Month, Day	h (Year)	place (State or Foreign ntry)				
	Director		247-44-8240	1 ☐ M 2 🛣 F	77	Yrs.	Months Days	Hours	Min.	05/11/			h Carolina	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c, Cit	y, Town or Lo	cation						10d. Inside City Limits	
	Maryla f sho	ō										1 ☐ Yes 2 ☒ No		
	28a-	Director	10e. Street and Number	11	FI	ulling	10f. Zip Code				10g. Citizen	of What Cou	ntry?	
	3a or	Ö	520 N. Park Street 29574								USA			
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Maryland 21215-0036	2 should be and Mental Is markad o aumatic eve	2	David Kemper	Page				Ju1i	ia Cl	ark				
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	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical C	29a. Certifier 1 Certifyir (Check only one)	ng Physician: To the Exeminer: On the b	best of my kno easis of examina ner stated.	owledge, deat ation and/or in	h occurred at the tim vestigation, in my of	ne, date an pinion, dea	nd place, a th occurre	nd due to the	cause(s) and date and pla	l manner as ce, and due	stated. to the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and little of continue				29c. License				29d. Date si	gned (Month	, Day, Year)	
			Della.	MIX)		D38	2958	3		5/6	12011	1	
11	5		30. Name and address of person	who completed gaus	se of death (Iter	n 23a) (Type,				Par A	LYNO	MI	2061	
	Sta Registr	160	31. Date filed (Month, Day, Year)	9 2011	Registrar's Signa		barker		- 0	.0	VI PVOL			
					A1	1-17								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2011 Gorman Lee Thayer 9:30 p.M May 14 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Oakland Nursing and Rehab Center 0akland Garrett If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Year) 1**X** M 2□ F Months Days 87 218-16-4128 Oakland, MD Director March 26,1924 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Expositer must be redified at 1 □Yes 2X No Director MD Garrett 0akland 2 should be filed within 72 hours after death with the I nand Mental Hyglene.
Is marked other than "natural", or items 23a or 28a-10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 119 Ann Kahl Road 21550 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WW I 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify. à Specify: 3 Widowed 4 Divorced White WW II Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Retail Mobile Elementary/Secondary (0-12) College (1-4or 5+) Salesman Home Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gorman Thayer Esther Hinebaugh ပ Arthur 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health au
Important: If item 27 is
any injury or other trau Rt. 1, Box 152-B Elk Garden, WV Esther Thayer/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State May 17 2011 1 ☐ Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smith Funeral Home Crematory Keyser, WV 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Smith Funeral Home S. Main Street Keyser, WV Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ling disease or condition resulting in death) ances /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No detached 9 Unknown cate has been signed by page 2 should be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 Maryes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate eneration 1/2 91 1 □Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation Il Director: A 1 ☐Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a TECTIFYING Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie Medical (Check only one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

- Ya

State Registrar Richard Porter, D.O.

31. Date filed (Month, Day, Year) / 32

25 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

311 N. Fourth Street Oakland, MD

32. Registrar's Signature

21550

Please Type or Print in Black Indelible ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Jame			- For State	or maryland / E	Certifica	ate of L	Death			Reg	No.		10/0	
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			 Facility Name (if not institution, give University Hospital 				Baltimore						nines (Etrito ne	
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	Director			M 2 4	10	Yrs.		_1		<u> </u>	1270	500	, my/ 1115	
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	radib Er 23		11. Merital Status	12, Was Decedent Ev Armed Forces?	er In U.S.	13, Was I	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuben, Mexican, Puerto Rica				14, Race White		an Indian, Black,	
		Funeral	1 Never Married 2 Merried 3 Widowed 4 Divorced	1 Yes 21	No		'es 2 □K'N				Specify: 1	whit	e	
	fir sal		15. Decedent's Education (Specify or	or Dates:			Usual Occupa			done 1	6b. Kind of Bu	siness/in	dustry	
,	215-0036 he filed within 72 hours after oral Hygiene. Thed other than "material", wet, the Medical Exempter.	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)			cse	A, DO POT D	ine leining)		Nurs	ing		
	5-0036 ded within 72 h Hygiene. Indicer than "a fin Medical E.	E	1 2 17. Father's Name (First, Middle, Last)					18 Mother's	Nama (Fir	st. Middle, Mei	den Sumame			
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	2121 Mid he fi Mental	2	19a. Informant's Name/Relationship (T				Address (Stre	et and Numb	oer or Rural	Route Number				
!	S table		Renae Williams-sister 3424 Shiloh Rd., Hamps											
	S 155 a		20a. Method of Disposition 1 Burist 2 Cremetion 3	Removal from State	20b. Piace of Dispo crematory or o				Date 20c Location - City o					
	Prest of	l	4 Donation 5 Other Specify:	4-16		Sykes								
	Baldimore, MD 21215-003 permit Pages I and a toold be filed with Oppariment of Health and Actual Hygiene, Imperiant of Health and Actual Hygiene Imperiant of Health and Actual Hygiene, Indusy or other transmitte event, the Mail	ſ	21. Signature of Furnament Service Licen	That der.	711		me and Addres						21157	
			23a, Part I, Enter the disease, or comp	lications that caused the	death, Don								Approximate Interval	
Physician /Medical 23a. Part I, Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line, immediate Cause (Final disease a. Gunshot Wound (1) of Chest and Left Upper Extremity										Between Onset and Death				
	Examiner	ı		Due to (or as a consequ					-					
Sequentially list conditions, b. Expuentially list conditions, b. Due to (or see a consequence of):														
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	oted id iansit	Examiner	events resulting in death) Last d.	Due to (or as a consequ	ience of):			•						
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	BOX 6 to death cerr the attendii	Physicia	1 Yes 2 No 9 V Unknown											
	VItal Records, P.O. Box 6 system: The law requires that the death ce his certifiers has been signed by the attend director, page 2 thould be the add for use	by P	Part II. Other significant conditions	contributing to death b	ut not resultir	ng in the un	derlying cause	given in Pe	rt f.				the cause of death?	
	Vaires Vaires Ald De	포							-	24a. Was an			topsy findings available	
	Records, The law require from has been if	Completed							-	Butopsy perform	ed?	prior to c death?	ompletion of cause of	
	Rec from S page	S								1 Yes 2	No 1	¥ Yo	s 2 No	
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		呈	29h, Signature and title of certifier					nee number		- 1			nth, Dey, Year)	
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	<u></u>		30, Name and address of person who Donna M. Vincenti, MD	completed cause of dec Assistant Medica			Penn Stree	et, Baltimo	ora, MD :	21201				
	S Regis	tate	31, Date filed (Month, Day, Year) APR 1 4 2	011 Sections	Signature .	60	Ne.			-				
	Mili 17 Pay 1/		2010											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 13 Day 2011 6:20 AM Williams Evelyn Burgess May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's St. Mary's Nursing Center Leonardtown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Days 06/11/1920 Hours Min. **Director** Washington,DC 577**-**18-1448 90 Usual Residence of Decedent show filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland St. Mary's Mechanicsville 10e. Street and Number 10g. Citizen of What Country? Funeral 39580 Four Seasons Drive 20659 S 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify. White Specify: 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygien.
Important: If item 27 is marked other than "ns
any injury or other traumatic event, the Medic (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Home <u>Homemaker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Brainard Recker Burgess, Sr. Lavinia Reinburg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen L. Haller/Daughter 39580 Four Seasons Drive, Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols Crem. 05/14/2011 Charlotte Hall, MD Sign it re of Funeral Service Licensee 22. Name and Address of FacilityBrinsfield-Echols Funeral Home, PA -M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Interval Between Onset and Death Immediate Cause (Final Physician/ quieare disease or condition resulting in death) Medical ue to (or as a consequence of **Examiner** Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of: or Attending Physician; The law requires that the death certificate be executed anding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical $\mathcal{L} \cup \mathcal{L} \vee \mathcal{L} \cup \mathcal{L} \cup$ 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Pregnant at time of death 5 Other (specify) Month Day g Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ours after death. eral Director; After this certificate has filled in by the funeral director, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 🗌 Yes Certificate: To 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work 1 🗌 Yes 2 🗌 No Investigation
Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b Signature and title of certif 5-13-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William D. Boyd, 25365 Point Lookout Rd., Leonardtown, MD 20650

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

gistrar's Signature

			Plea	se Type or Pr				_		_		
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E	xamine		a. Facility Name (if not institution,	give street and number)	. 1	4b. City, Town,	or Location of Death		40	c. County of Deatl	h	1
	uneral rector	5		6. Sex 1 M 2 X F	ge (In yrs. last birt	hday) If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth	1	Cou	hplace (State br	
ס	0 t		Jsual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					10d. Inside City	v Limits
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Division of Vital Records, ral or Attending Physician: The law requires safter death.	irector	Certificate:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of Ir	njury - At home, fa etc. (Specify)	rm, street, factory, office	,	28f. Location (S City or Tow		nd Number or Ru 'e)	ral Route Numb	er,
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	le Fune	Medical	(Check 2 Medical E	Physician: To the best of xaminer: On the basis of Nurse Practioner: To the	examination and/	or investigation, in my opin	nion, death occurred a	t the time, date a	nd plac	ce, and due to the	cause(s) and mai	nner stated.
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CR S	7		SOUTHEAM M	NO COMPLETED CAUSE OF	1-105F	MAL: 7:	503 5011	ars ,	Re	. S Ch.	nlan M	10/35
	State	е	30. Name and address of person of the LN M31. Date filed (Month, Day, Year)	MAY 1 0 201	trar's Signature	A h	ukil					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death MAG WALCS Physician/ Month GLORIA 0445 RANCES Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death ANNE ARUNDEL ANNAPOLIS ANNE ARUNDEL MEDICAL CENTER 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** Months Days Hours Min MARYLAND 220-34-3363 1 \square M 2 Yrs Director SEPT. 1936 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he martitual any once. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director PRINCE GEORGE'S BOWIE Yes 2 No MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20715 4906 COLLINGTON ROAD 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Armed Force Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 🌠 No Specify: 3 → Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE 12TH ATTENDANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည HARLEY LOUIS PROCTOR STELLA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 549 OLD STAGE ROAD GLENBURNIE, MARYLAND 21061 WELLS/SON JOSEPH Κ. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) RESURRECTION CEME. 5/11/2011 CLINTON, MARYLAND 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. Signature of Funera Service Licenses 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the dis shock, or heart failu Immediate Cause (Final complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death diseas Ph. sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** RTENSION MONTHS ULMON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying MONTS Exami UCMONA Cause (Disease or iinjury and that initiated events resulting in death) Last use as the burial-trail Due to (or as a consequence of): attending physician for use as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Month Year Pregnant at time of death the a Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 2 House after death.

E Huneral Director: After this certificate has been a Funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No Yes 2 N Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: ၉ 1 Yes ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred iniury 1 Natural 5 Pending M Accident Investigation completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one) Signature and title 6 29c. License number Date signed (Month, Day, Year) 20

State Registrar

DHMH 17 Rev 7/2009

Name and address of perso

2011

Date filed (Month,

DEDENSE

MARIYU

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

NTA

			Please	Otata of Man				-	•	•
			For State	State of Mar		artment of t tificate of t			201	1 16756
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	uncate of t	Dealii	2. Date of Dear	Reg. No. — U	3. Time of Death
	Physicia Medio	cal	Mitch	ell H. War	ren			Month May 2	2, 2011 Year	5:20 P M
السا	Examin		4a. Facility Name (if not institution, give si 5026 Silver Hill	Court # 10	3	Dis	r Location of Death trict Hei			George's
	Funeral Director		<u> </u>	7. Age (li	n yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb. 3,	Year 9. Bi	rthplace (State or Foreign ountry) Maryland
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	Usual Residence of Decedent 10a. State 10b. County		Oc. City, Town or Loc	cation	Faras	tville		10d. Inside City Limits 1 ☒ Yes 2 ☐ No
	the Ma or 28e e notif	Dire	Maryland Prince Ge 10e. Street and Number	eorge's		10f. Zip Code	roles		10g. Citizen of What C	
	n with rs 23a nust b	Funeral	5026 Silver Hill	Court # 10	3	2	.0747		Unite	d States
10	r death or item niner n	by Fu	11. Marital Status 1 ☐ Never Married 2 🏝 Married	12. Was Decedent EveArmed Forces?1 ☐ Yes 2 ☒ No	l II	Vas Decedent of F Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
Baltimore, Maryland 21215-0036	ours afte ntural", c al Exan	eted b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.	1	Yes 2 No			Specify: B1	
215-	n 72 ho an "na Medic	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4 or 5+)	(Give H	O NOT use retired)	during most of work	_	16b. Kind of Business	
21	withi		12th		S	tock/Cas	hier Cler			ivate
and	e filec ntal H ed otl	To Be	17. Father's Name (First, Middle, Last)	11 77 77	a			ne (First, Middle, M	Maiden Surname)	unk.
ĬŽ	ould booking Mei	-	M1tcr 19a. Informant's Name/Relationship (Typ	ell H. War	7	a Address /Ctrast		stelle	City or Town, State, Z	
, Ma	and 2 shu Health an tem 27 is		Cecelia T. Warren				L11 Court		orestville	, Md. 20747
nore	age 1 a out of H tell (or oth		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 F		-	natory or other pla	^{ce)} Mav	Date 11 2011	20c. Location - City o	r Town, State Maryland
altin	mit. Pa bartme bortan r injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses	e () 1 -		mony . Name and Addre			neral Home	
m	Depar Depar Impor any ir	. 17	John T.	Stewar	20				nington, Do	
			23a. Part T. Enter the disease, or complishock, or heart failure. List only one Immediate Cause (Final	cause on each line.					est,	Approximate Interval Between Onset and Death
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	ted Insit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	bue to (or as a c	onsequence on.					1
	oe executed ician and burial-transii		that initiated events resulting in death) Last	Due to (or as a co	onsequence of):					
260	physic the bi	edica		l						
89	certific inding use as	m/M	IF FEMALE: 23b. Was decedent pregnant 23	Bc. If yes, outcome of] Fatania anagan			23d. Date of d	eliv e ry
. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live Birth 2 4 Pregnant at tir 9 Unknown		Ectopic pregnan Other (specify)			Month	Day Year
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ords	requir been s should	letec						24a. Was a		utopsy findings available
Reco	The law ate has bage 2:	Completed						autops perfor 1 Yes	sy prior to	completion of cause of
tal	cian: ertific ector,	Be	25. Was case referred to medical examiner?	ospital:			lace of Death (Chec			
Š	Physical direction	<u>ان</u>	1 ☐ Yes 2 🛂 No	1 Inpatient 28a. Date of injury	2 ER/Outpatien 28b. Time of	t 3 DOA Oth	4 LI Nursing H		ence 6 Other (Spe	ecify)
o uc	inding ath. r: After re fune	icate	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Y		wor	k? Yes 2 □ No	Zed. Describe no	ow injury occurred	
Division of Vital Records, P.O.	or Attendi after death Director: A in by the fi	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (\$	- At home, farm, stre Specify)	eet, factory, office		28f. Location (St City or Town	treet and Number or R n, State)	ural Route Number,
Ω	To the Hospital or Attending Physician: The law within 24 Hours after death. To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2 s	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examine	er: On the basis of exam	nination and/or invest	igation, in my opini	ion, death occurred a	at the time, date ar	nd place, and due to the	cause(s) and manner stated.
,	To the within 2 To the comple	ž	only one) 3 Certifying Nurse 29b. Signature and title of certifier	Practioner: To the bes	st of my knowledge, c	leath occurred at the 29c. Licens			cause(s) and manner a 29d. Date signed (Mon	
			Motilda H	. So. M	D ·		D26250		May 5,	2011
1,0	4		30. Name and address of person who co	•			Manulan 1	20774		
1	Sta	te	31. Date filed (Month, Day, Year)	21 Mercant 32. Registraris			гагулапо	20114		
	Registra		MAY 1 0 2011	Engra B.	Signature					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	-	For State	of Maryland / [Departmen [.] <i>Certificate</i>				2	011	10757
		Registrar 1. Decedent's Name (First, Middle, Last)		Certificate	, 01 1	Catif		Reg. No. /		3. Time of Death
Physicia Medio		MARGARET ANN TOWN	SEND WILKE	ERSON]	2. Date of De Month May 7,	2011	Year	8:30A ^M
Examin	er	4a. Facility Name (if not institution, give street and r	Sec.			Location of Death		4c. Cou	unty of Death lerset	
Funoval		7410 Pocomoke River 5. Social Security Number 6. Sex	7. Age (In yrs. last birtl	hday) If Under	1 Year	ce City If Under 24 Hrs.	8. Date of Bir	th	g, Birth	place (State or Foreign
Funeral Director		225-32-9820 1 M 2 X	F 81	Yrs. Months	Days	Hours Min.	01/31/	1930	Mary.	land
how at	١	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	n or Location					T	10d. Inside City Limits
farylar 8a-fs tified	Director	MD Somerset	Pocomoke	e City						1 ☐ Yes 2X No
a or 2 be no		10e. Street and Number		10f. Zip				0	of What Cou	ntry?
th with ms 23 must	Funeral	7410 Pocomoke River Ro	ecedent Ever in U.S.	218		spanic Origin? (Spe	acify Yes or No-	USA	Race - Americ	can Indian
or ite	by Fu	1 Never Married 2 Married 1 Y	Forces? es 2 🔀 No	If Yes, speci	ify Cubar	n, Mexican, Puerto			Black, White,	etc.
urs aft ural",		3 Widowed 4 □ Divorced If Yes, Year o	Give r Dates.	1 Tes 2					^{cify:} Whit	
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filed within 72 hours after death with the Maryland all Hygiene. A constant of the first than "natural", or items 23a or 28a-f showent, the Medical Examiner must be notified at		Elementary/Seconday (0-12) College 1 2		memaker	-			Dome	stic	
be filed ental Hy ked oth	To Be	17. Father's Name (First, Middle, Last) E. Franklin Townser	v a			18. Mother's Nam Anna Ju		Maiden Surr	name)	
should be filed within a and Mental Hygiene. I is marked other tha raumatic event, the I		19a. Informant's Name/Relationship (Type, Print)		. Mailing Address				er, City or Tow	vn, State, Zip	Code) 23415
e, Me and 2 sh Health ar tem 27 is		Lynn Abbott/ Daught	er 2	5286 Pi	tts	Creek	Road,	New	Churc	h, VA
2 - 2 E 5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fi	om State cemeter	f Disposition (Nam ry, crematory or o	ther place	e)	Date		ion - City or T	
Datumori permit. Page 1 Department of Important: If i any injury or o		4 Donation 5 Dother (Specify)	Salis	bury Cr			· ·		oury, N	-
Dall		21. Signature of Figure 21. Service Licensee	n	107 Vir	ie St	is of Facility Hol creet, Po	.loway E comoke	unera. City,	Home MD 218	951
		23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause of	each line.			. 0				Approximate Interval Between
Physician/ Medical		Immediate Cause (Final disease or condition a.	pronic Le		Hea	ut B	sease			Oneet a digith
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of ou		IF FEMALE:				-				
death certific	Physician/M	23b. Was decedent pregnant 23c. If yes,	outcome of pregnancy ive Birth 2 Fetal death regnant at time of death	h 3 🗆 Ectopic p		У		230	I. Date of deliversity of Month	very Day Year
he dea y the a	hysic		Inknown	5 🗆 Other (sp						
that the	by P	Part II. Other significant conditions contributing	to death but not resulting	in the underlying o	cause giv	en in Part I.				the cause of death?
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an: The tificate tor, pa	Be Co	25. Was case referred to medical			26. Pla	ace of Death (Chec		2 X No	1 LJ Yes	2 No
VILAI hysician: his certific	고 B		☐ Inpatient 2 ☐ ER/O		Othe	er: 4 Nursing H	ome 5 KResi	dence 6	Other (Special	fy)
DIVISION OF all or Attending P. 's after death. 'al Director: After the ed in by the funera	ate:	1 Natural 5 ☐ Pending (/		Time of 2 injury M	8c. Injury work	yat ? Yes 2 □ No	28d. Describe	how injury oc	curred	
Attender deat sector:	Certificate:		ace of Injury - At home, fa			700 2 2 110			umber or Run	al Route Number,
urs after all Dir		0	uilding, etc. (Specify)				V	wn, State)		
DIVISION OF VICE THE PROPERTY FOR BOX 00/00. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affer death. To the Funeral Director: Affer this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To t (Check 2 Medical Examiner: On the only one) 3 Certifying Nurse Praction	basis of examination and/o	or investigation, in	my opinio	on, death occurred a	at the time, date	and place, an	d due to the c	ause(s) and manner stated.
To the within To the compl	Σ	only one) 3 Li Certifying Nurse Praction 29b. Signature and title on certifier	To the best of my know			number		29d. Date s	igned (Month,	, Day, Year)
		SARAD	R. BAR	ALNO		0544	22	05	5-09	-2011
BA 5		30. Name and address of person who completed	St. Por	em ak	e,	D544.	2185	5/		
Sta Registr		31. Date filed (Month, Day, Year)	2. Pegistrar's Signature	harke	,			-		
riegisti	OII .	11111 - 1 4011	comment.	/T						

DHMH 17 Rev 7/2009

11-03294 Debra Lynn Wolfe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ebra Lynn Wo	lfe	Registrar	partment of <i>ertificate of</i>		Re	20 l	1675
Physic Medical Exam		1. Decedent's Name (First, Middle,Last) Debra Lynn Wolfe			2. Date of Deal Month April 30, 2	Day Year	3. Time of Death 1710 hrs
JEUICAI EXAII	iiic.	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of D		4c. County of Death	
		13832 Weaver Avenue		Maugansville		Washington	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	s. last birthday) Yrs.			th(MM/DD/YYYY) 9. Bir /1957 Foreig	
any		Usual Residence of Decedent 10a. State 10b. County 10c. Ci	ity, Town or Locati	ion			10d. Inside City Limits
. .	7	MD Washington	Mau	gansville			1 X Yes 2 No
Maryla 28a-f d at on	Director	10e. Street and Number		10f. Zip Code 21767	11	og. Citizen of What Cou	ntry?
with the Maryland 18 23a or 28a-f sho	iO le	13832 Weaver Ave.	IIO IAO IVA		/ Specify Vener No	USA	iona Indian Plant
eath wi	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Ye	is Decedent of Hispanic Origin? es, specify Cuban, Mexican, Pu		White, etc.	ican Indian, Black,
after d	by Fu	3 Widowed 4 Divorced If Yes, Give Yeer or Dates:		Yes 2 No specify:		Specify:	White
hours natur		15. Decedent's Education (Specify only highest grade completed)		t's Usual Occupation (Give kindost of working life. DO NOT use		16b. Kind of Business/	Industry
0036 within 72 hours after death with the Maryland giene. her than "natural", or itema 23a or 28a-fahe. Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ho	memaker		own	home
F E F E	Ве Соп	17. Father's Name (First, Middle, Last) Ralph C. Snoots		Hilo	lame (First, Middle, M la Welty		
shoul shoul	To	19a Informant's Name/Relationship (Type, Print) Richard Wolfe Sr. (Husbar	nd) 138	Address (Street and Number 32 Weaver Av	or Rural Route Num 7e • • Mau		
Baltimore, Wi permit. Pages 1 and 2: Department of Health a Important: If item 2: jupagy or other traum				ition (Name of cemetery, her place) COB Cemetery	Date 75/6/201	20c. Location - City or LMyersvil	
Baltin permit. I Departm Imports		21/Signature of Full-bran Service Licensee	22. N P	ame and Address of Facility Onald B. Tho OB 18, Middl	ompson F Letown,	uneral Ho MD 21769	me
Physician		23a. Part. Enter the disease, or complications that caused the dea failure. List only one cause on each type.					Approximate Interval Between Onset and
/Medical		Immediate Cause (Final disease or condition resulting in death) a. Diabetes Keto Due to (or as a consequence					Death
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	iner	if any, leading to immediate Due to (or as a consequence cause. Enter Underlying Cause	э of):				
uted ud ransit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence d.	∋ of):				
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760 ficate to g physis s the bu	/Me	IF FEMALE: 23b. Was decedent pregnant in the	regnancy	tal death 3 Ectopic pro	egnancy	23d. Date of delivery	y Day Year
Box 6876 e death certificate the attending phy ed for use as the l	iciar	past 12 months? 4 Pregnant at time of		her (Specify)	egitaticy	World	Suy 100.
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, P.O.		Left femoral artery thrombosis, ather	-			2 No 3 Prot	-
rds, require been si	Completed by				24a. Was a		utopsy findings available
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	ldmc		-		perfor	med? death?	
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on of of the control	ion:	27. Manner of Death 1 3 Natural 5 Pending 28a. Date of Injury (Month, Day, Year)	28b. Time of Ir	njury 28c. Injury at Work?		now injury occurred	
Division pital or Attent ours after death eral Director: filled in by the	ficat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - Al	t home, farm, stree	et, factory, office building, etc.		treet and Number or Ru	ıral Route Number, City
Div e Hospital o 24 hours af e Funeral D	Certification	4 Homicide determined (Specify)			or Town, S	tate)	
Div To the Hospital or within 24 hours afte To the Funeral Dis	Medical (29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.					
	Ž	29b. Signature and title of certifier	A	29c. License number		29d. Date signed (Mo.	nth, Day, Year)
		30. Name and address of person who completed cause of death (lit	em 23a)	O.C.M.E.		May 1, 2011	
		Zabiullah Ali, M.D. Assistant Medical Examine		altimore Street, Baltimo	ore, MD 21223		
S Regis	tate trar	20.000 - 20.0000	ature				

ORIGINAL

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Plea	se Type or			ndelible In			•		_	jible.		
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Physicia		Decedent's Name	e (First, Middle	•	R. Yo	ung, Jr				2. Date of De		ay 2	Xear/	3. Time of I	Death M
Medic Examin		4a. Facility Name (if	not institution	, give street and nun			4b. City, Town, o	or Location o	f Death		40	c. County	of Death	1 - 00)	
<i>J</i>		Western 5. Social Security No	Maryl	and Healt			Cumberland					A11eg			
Funeral Director		234-60-38	348	6. Sex 1 X M 2 □ F	7. Age (In y	rs. last birthday, 2 Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Bin 11/16/		8	9. Birthplace (State or Foreign Country) Gaines, WV		
at at	ě	Usual Residence of 10a. State	10b. County		10c.	City, Town or L	ocation							10d. Inside City	y Limits
Maryla 28a-f s	rect	WV	Miner	al		Keyser								1 🗌 Yes	2 💢 No
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should and N is ma auma		19a. Informant's Na	me/Relations	nip (Type, Print)		1	ling Address (Street						State, Zip	Code)	
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Physician/ Medical Examiner		23a. Part 1. Enter the shock, or hear Immediate Cause (I disease or condition resulting in death)	t failure. List o Final	complications that only one cause or early one cause or early one to	caused the dich line.									Approximate Interval Betw Onset and D	/een
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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Vitl Con		29b. Signature and	title of certifier		1		29c. License			29d. Da	ate signed (Month	
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State Registrar Nishi Rawat, MD 31. Date filed (Month, Day, Year) MAY 1 0 2011

Columbia, MD 21044

5755 Cedar Lane
52 Registra's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ JOHN T. ALLEN 8.25A M MAT 20 Medical Town, or Location of Death Baltimore 4a. Facility Name (if not institution, give street and number) 4b. City. 4c. County of Death Examiner Loch Raven VA Rehabilitation 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 213-60-3651 1 3M 2 F Months Country) 59 Director 07/05/1951 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Baltimore MD Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 21213 Funeral 4100 Eastmont Avenue items 23a 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces? Black, White, etc þ 1 Never Married 2 Married 9 X Yes Maryland 21215-0036 Black 1 Yes 2 No Specify: Hygiene. other than "natural", If Yes, Give Completed 3 Wildowed 4 X Divorced Army Year or Dates. traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Clerk Food 12 and Mental Hygie is marked other Be be filed 18. Mother's Name (First, Middle, Maiden Surname)

Lucille Har 17. Father's Name (First, Middle, Last) Harris Julius Allen permit. Page 1 and 2 should Department of Health and Me Important: If item 27 is mari 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5709 Adleigh Avenue, Baltimore, MD Angela Allen/Daughter or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/28/2011 Woodbine, MD Final Journey Crem. injury (21. Signature of Euneral Service Usensee Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD e Marsha 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Atherosclastic Fnysician disease or condition resulting in death) Medical Due to (or as a consequence of) Examine teas Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as consequence of) requires that the death certificate be executed the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant a 9 Unknown Pregnant at time of death 5 Other (specify) signed by the a 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed page 2 should I peen Were autopsy findings available prior to completion of cause of 24a. Was an the Hospital or Attending Physician: The law certificate has autopsy perform death? 1 Yes 2 No Yes director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: No မ To the Hospital or Attending Physical by within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directors. 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide Medical 1. Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Ca tamakanua 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABSOLA FAMAKINGA MD, 3906 LOCH RAVEN BIND BALTIMARES MD

State Registrar nth, Day, Year)

26 2011

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5 Physician/ Year 2011 Addison Elsie Jane 6:55 P M . Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ivy Lane Anne Arundel Glen Burnie Social Security Number If Under 1 Year 6. Sex If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 08/25/1929 1 🗆 M 2 🖾 F Months Hours Min 213-26-9723 MaryTand 81 Yrs **Director** Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 K Wo Anne Arundel Glen Burnie MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21060 12 Ivy Lane U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2X Married δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the In Air Craft Manufacturer 12 Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John C. Denner Mary A. Lease 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IVY Lane Glen Burnie, MD 21060 12 Mr. Lewis H. Addison/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of May Date 31 20c. Location - City or Town, State cemetery, crematory or other place)
Vet Cemetery 1 X Burial 2 Cremation 3 Removal from State Crownsville, MD MD 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility} Singleton Funeral & Cremation Services PA 1 2nd Ave SW Glen Burnie, MD 21061 Signature of Funeral Servi 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Du to (or as a consequence of): Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: ဂ္ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 🗌 No Accident Investigation 2 ☐ Accider 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) May 2414 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 2. Date of Death 22 2011 4c. County of Death 4b. City, Town, or Location of Death HOSDITAL AGNES BALTIMORE Date of Birth (Month, Day, Yea 11/18/26 If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Hours Days 1 M 22F Maryland 84 10c. City, Town or Location Pasadena Anne Arundel

3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 03:55 PM <u>Ellen G. Ash</u> /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** SAINT 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Director 216-20-0360 Usual Residence of Decedent 10d. Inside City Limits 10a. State show th and Mental Hyglene.
7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director permit. Pages 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "nature" any injury or other traumatic auce. 10g. Citizen of What Country? 10e Street and Number USA 21122 2196 228th Street Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. □Yes 2No 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify. White 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Misty Harbor Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Louise Parlett Joseph L. Gilman ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pasadena, Maryland 21122 2196 228th St. Ellen Feuchtenberger / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery | 5/28/11 Baltimore, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Loudon Park Fineral Home 21. Signature of Funeral Service Licens 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on yone cause on each line. Approximate Interval Between Onset and Death GASTROINTESTINAL BLEEDING Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Throm Bosis Examiner IMONTH VEIN if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.Ö. Box $68760^{\sim}_{
m c}$ Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 morths?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by ITE I MER DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2∭ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🕜 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CATON AMAR 31. Date filed (Month, Day, Year)
NAY 26 2011 32 Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician/ Day Year UGUSTA ANDERSON 5:09 PM MAY 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HARBOR BALTIMORE HOSPITA Social Security Number 9. Birthplace (State or Foreign Country) Mary land Age (In yrs. last birthday, 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 🗆 M 2 🗹 Months Director Usual Residence of Decedent 10a, State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code ò 10g, Citizen of What Country? pe Funeral permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a any injuy or other traumatic event, the Medical Examiner must b. UST 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever Ju U.S 14. Race - American Indian, Armed Forces?
1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: Black If Yes. Give 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Maryland Cup Corp Laborer Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Clutc uanta 19a. Informant's Name/Relationship (Type, Print) City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Bural Route Number, Cromer -50h Kd. Baltimere 20b. Place of Disposition (Name of 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place andsdowne 4 Donation 5 Other (Specify) Zion Cemeter 21. Signature of Funeral Serpice Licensee uneva Mar lar 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Appro imate Interval Between Immediate Cause (Final Onset and Death ARDS Physician disease or condition resulting in death) WEEKS Medical Due to (or as a consequence of): Examiner PNEMONIA 2 WEEKS Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami or Attending Physician: The law requires that the death certificate be executed CIRRHOS15 UNKNOWN Cause (Disease or linjury LIVER within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical $\mathcal{M}\mathcal{L}$ ision of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 l 9 I Ilnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HEPATITIS C ABUSE ALCOHOL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ► No 24a. Was an autopsy performed? 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined Hospital of 24 hours at Medical 29a, Certifier 1 🙇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MAY 2011 RES-000 23 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATTHEW FANELLI 3501 SOUTH HANDVER STREET BALTIMORE, MARYLAND 31. Date filed (Mar 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 05 A^{M} MORRIS ANDREWS 8 2011 11:15 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 751 W. SARATOGA ST APT 413 BALTIMORE Social Security Number 1 Year If Under 24 Hrs. If Under Birthplace (State or Foreign Country) **Funeral** . Age (In yrs. last birthday) 8. Date of Birth 1 X M 2 □ F Hours 08-12-1931 Director 217-24-8843 79 MD Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10b. County filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 751 W. SARATOGA ST. 21201 APT 413 U.S.A. n "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married ð ☐ Yes 2 🏋 No Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Completed BLACK Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 11th PRINTING PRESS permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other t any injury or other traumatic event, th PRINTING OPERATOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MORRIS ANDREWS ELIZABETH ELEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANGEL ANDREWS/WIFE 751 W. SARATOGA ST. BALTIORE, MD 21201 APT 413 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) METRO CREMATORY 05-24-2011 BALTIMORE, MD 21201 21. Signature o n Al Signature WILLIAM C. BROWN COMMUNITY FUNERAL HOME P.A. 1206 W. NORTH AVE. BALTIMORE, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line Immediate Cause (Final PROSTATE CAMER Onset and Death Physician/ METASTATIC disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 \square Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No after death Director: / Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address use of death (Item 23a) (Type, Print) Baltimore MD 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

6 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 24, Physician/ Olive B. Albrecht 2011 8:50 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Presbyterian Home Towson 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 M 2 XF Hours 219-01-9464 10//27/1917 Maryland **Director** 93 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at **Funeral Director** Maryland Baltimore Towson 1 🗌 Yes 2 ื No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? items 23a 513 Piccadilly Road 21204 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 i Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n: any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mary Catherine Murphy Julian Brinsfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8007 Harris Ave. Douglas Albrecht / Son Baltimore, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) 5/27/2011 Baltimore, Maryland oudon Park Cemetery 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phylician neumon disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death g | Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by nises. Division of Vital Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 🔼 No Yes eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 ANatural 5 Pending work? 1 \(\subseteq \text{Yes} \) 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 037016 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Level St., Scite 4104 Baltinon, mo 21204 31. Date filed (Month, Day, Year, State 6 Registrar

DHMH 17 Rev 7/2009

11-038	353
Robin	Bock

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month Day May 23, 2011 Medical Examiner Robin M. Bock 0923 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 909 #A Pine Road Harford Joppa 5. Social Security Number **Funeral** 6. Sex Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Maryland Months Days Hours Director November 10,1957 212-70-1243 53 M 2 XF Yrs Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits or 28a-f show Maryland Yes 2 XNo Harford or items 23a or 28a-f sho must be notified at once, Joppa permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 909 #A Pine Road 21085 United States Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married Yes If Yes, Give Year Widowed 4 X Divorced Yes 2 X No specify: Specify: White "natural" ۾ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical 21215-0036 Caregiver Home Health 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be marked Robert Gwaltney 19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21236 MD. Robert Gwaltney (Father rtant: If item 27 7615 Belair R<u>oad</u> Baltimore, Marvland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, Burial 2 X Cremation 3 crematory or other place) Evans Funeral Chapel-Bel May 26, 2011 Forest Hill, Maryland Other Specify Donation 5 Signature of Funeral Service Licenses Name and Address of Evans Funeral Chapel & Cremation Services Parkville 8800 Harford Road Parkville, Maryland 21234 complication: that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician ist only one ause on each line. een Onset and /Medical Death a. Hanging Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical ned by the attending physician detached for use as the burial UNPENDED AMENDED Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of 5 Other (Specify) 1 Yes 2 No 9 ✓ Unknown g Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 23e. Did tobacco use contribute to the cause of death? þ σ. Yes 2 V No 3 Probably 4 Unknown Completed Records, has been s e 2 should l 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? s certificate h Yes 2 V No No Yes To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical of Vital 26.Place of Death (Check only one) examiner? Other₄ Hospital: 1 ER/Outpatient 3 DOA After this Inpatient 2 Nursing Home 5 Residence 6 V Other: Scene 1 V Yes ဥ 28a. Date of Injury (Month, Day, Year) FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject hanged self FOUND Division Natural Pending Yes 2 V No the May 23, 2011 0910 hrs 2 Accident Investigation in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 🗸 Suicide Could not be or Town, State) 909 #A Pine Road, Joppa, MD filled determined (Specify) Multi-Family Apt. To the Funeral Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated **Medical** 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001 **OCME 2006**

State

30. Name and address of person

31. Date filed (Month, Day, Year)

Jack Titus MD.

32. Registrar's Signature

tho completed cause of death (Item 23a)

Deputy Chief Medical Examiner

O.C.M.E

900 W. Baltimore Street, Baltimore, MD 21223

May 24, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ James Marshall Bullock Month May 25 2011 11:35 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 67 Wood Duck Lane Elkton Cecil Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
PA **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 05/15/1961 Months Days Min 181-52-1190 50 **Director** Usual Residence of Decedent or 28a-f show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27.5 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified as any injury or other traumatic event, the Medical Examiner must be notified as 10c. City, Town or Location 10d. Inside City Limits Director Cecil MD Elkton 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 67 Wood Duck Lane 21921 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. δ 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X☐No Specify. Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Marine Mechanic Marine 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Majorie Meadowcroft Eugene Robert Bullock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code; 67 Wood Duck Lane, Elkton, MD 21921 Arlene M. Bullock/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crem 5/27/2011 Woodbine, MD 21. Signature of Funeral Service Licenses Dorfota Marshall 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ore cause on each line. Interval Between Immediate Cause (Final Onset and Death Cancol Physician/ disease or condition resulting in death) anchear Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ atter for L in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death Day ned by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| sign. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 🔑 or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ည 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No nours after death.

neral Director: Aff Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Hospital 24 hours Medical Medical Examiner: On the bast of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check within 2 Certifying Nurse Practioner: To the best of my knowledge, death accurred at the time date and place, and due to the cause(s) and manner as state Signature and title

Registrar

State

Baltimore,

Box 68760

P.0.

Records,

Division of Vital

Stemmers Ruen RD Baltimorze, 2-1201

Name and address of person who completed cause of death (tem 23a) (Type, Print)

Charbon (LIT Stemmer

31. Date filed (Month; Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2:45 Physician/ Mai 01 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Georges World Living andover rince Assisted 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Country) Month, Day, Year Hours Min. 1 🗆 M 2 🕱 F Days -20-984 mia Director Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natura" any injury or other traumatic events. 10b. County 10c. City, Town or Location 10a, State Director 1 Yes 2 No Rowie Maryland Trince 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 20 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 🗷 No 1 ☐ Yes 2 🗷 No Completed 3- Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) dmont Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mabi mc19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Andriette Heatherstone Dr. Md. onc 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Bland Family (emeter 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Funeral Home 504 East Street Blackstne Va 2384 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Atherosclerotic Immediate Cause (Final Physician 3 yea disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Physician/Medical Examiner Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Month in the past 12 months?
1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 2 🗆 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certificate 2 N N director, 25. Was case referred to medical 26. Place of Death (Check only one) 읆 Assisted examiner? Other: 4 \(\sum_{\text{Nursing Home}}\) Hesidence 6 \(\overline{\text{M}}\) Other (Specify) Hospital 2 No ER/Outpatient 3 DOA 1 Yes 1 Inpatient 2 I Certificate: To 28a. Date of injury (Month, Day, Year) 28c. Injury at completed filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural work? 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide City or Town, State) To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 5/26/2011 037934 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greenway Ctr Drive Greenbelt MD 20770 Trifoglio MA 7500 ephanie 31. Date filed (Month, Day, Year, 32. Registrar's Signature State

Registrar

26

2011

To the within 2

21215-0036

Baltimore, Maryland

Box 68760 Geath certificate be executed

P.O.

Records,

of Vital

Division

law requires that the

Hospital or Attending Physician: The

death.

Page 1

Registrar DHMH 17 Rev 7/2009

State

only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

arke

32. Registrar's Signature

ELLORE

29c. License number

2

29d. Date signed (Month, Day, Year)

Perry Point Bldg 361, Perry Point, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 24,2011 Physician/ Elizabeth Teresa Baldwin 9:15P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Pylesville 4426 Graceton Road If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 🔯 Months Davs Hours Min (Month, Day, -10-192 83 214-26-1609 Director Maryland Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Harford Pylesville 1 Tes 2 No Md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21132 USA 4426 Graceton Road death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2X No Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2X No Specify: White If Yes, Give 3 🕅 Widowed 4 🗆 Divorced "natural" Year or Dates. other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Church Organist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Elizabeth Huber John Tanner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health BelAir, Md. 21014 DTR. 1718 Pine Forest Ct. Carol Kehl 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ō <u>=</u> Important: If any injure cemetery, crematory or other place) 1 ABurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-28-2011 Fullerton, Md. Joseph 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Nottingham, Md. 21236 9705 Belair Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Other (specify) Month Year Pregnant at time of death 9 Unknown P.O. | signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred the Hospital or Attending 1 Natural injury 5 Pending 2 🗆 No Accident Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature ap 29d. Date signed (Month. Day. Year Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 25. Month Year 2011 3:30 AM Physician/ May Deborah Ann Borges Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Ellicott City Health & Rehab. Ellicott City Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
May 20 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months 1 M 2 X F Country) Connecticut 54 195 045-52-6334 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State Director must be notified 1 ☐ Yes 2 🛣 No 28a-f Catonsville Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code 0 23a Funeral United States 21228 403 Shade Tree Place Apt. K death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🏞 No If Yes, Give Year or Dates Specify Black 3 Widowed 4 Divorced 27 is marked other than "natur traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other than Medical Book Keeper Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည James Whitaker Gloria Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 403 Shade Tree Place Apt. K Catonsville, MD 21228 Borges DeNeal /Daughter Important: If item 2 any injury or other once. other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 ŧ May 2 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 Chesapeake Crematory Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives MO1585 Robec 8717 Green Pastures Drive Towson Maryland 21286 Mon 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ work monather disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter onderlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) ned by the a Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by certificate has been sign rector, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 ☐ Yes 2 ☐ No ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie D47683 5725/11 Taymord Mille 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smith Sinte 203 2835 Avenue 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene,... State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2 0 1 1 Month Physician/ Dollie E. Barnhart 24 4:25P M May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospice Dove House Westminster Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🗶 F Hours Min. 1 / 0 3 / 1 9 2 9 MD Director 212-24-5141 81 Usual Residence of Deceden or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 No Carroll Westminster MD 10e. Street and Number 10g. Citizen of What Country? iral", or items 23a o Examiner must be Funeral 21158 USA 1245 Carrollyn Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces 1 ☐ Yes 2 🕅 No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates is marked other than "natu aumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance 12 Customer Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mamie Green Ollie Porter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1215 Carrollyn Dr., Westminster, MD 21158 Ralph E. Barnhart-son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ь 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/27/2011 Finksburg Evergreen Mem. 22. Name and Address of Facility Fletcher Funeral Home 21. Signature of heral Service Licensee Main St., Westminster, MD 21157 254 Ε. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final severe Colitis Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of). the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant a Pregnant at time of death 5 Other (specify) 2 🛂 No Yes 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\overline{\cup}\) Other (Specify) HOSPILE Hospital: ျ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28c. Injury at Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) only one 29c. License number 29b. Signature, and title of certifie 25 echo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminster GACKO

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year NAY 26

2011

Registrar's Sign

11-03736

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State of Maryland / Department of Health and Mental Hygiene	<u></u>	U	- 1) [· 1	

riazian L Best		State of Maryland / Department of 1-For State Certificate of Registrar		, ,	g. No.	10111				
Physiciai Medical Examin	n/	1. Decedent's Name (First, Middle,Last) FIAZIAH L. BEST		Date of Death Month	h Day Year	3. Time of Death 1010 hrs				
REGICAL EXAMINI	GI		4b. City, Town, or Location of Death	May 18, 20	4c. County of Death					
		Baltimore Washington Medical Center	Glen Burnie	10.0	Anne Arundel					
Funetal Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 153-70-2449 1 M 2 F 31 Yrs	Months Days Hours Min.	_	h(MM/DD/YYYY) 9. Bir Foreig -1980					
any	ł	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locat	on			10d. Inside City Limits				
Maryland 28a-f show	5	MD. ANNE ARUNDEL GLEN BUR	NIE			1 XXYes 2 ☐ No				
or 28a-	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Coul	ntry?				
with th		301 PHELPS AVE . 11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa	21060 s Decedent of Hispanic Origin? (Sp	ecify Yes or No-	USA 14. Race - Ameri	can Indian, Black,				
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21,7 hould b nd Men is mar		19a. Informant's Name/Relationship (Type, Print)	Address (Street and Number or R	tural Route Numi	ber, City or Town, State					
and 2 sleath ar cen 27 traums	ŀ		SOUTH 12th ST. 1	NEWARK,	NEW JERSEY 20c. Location - City or					
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr		1 Burial 2 Cremation 3 Removal from State crematory or other	er place)							
altin mit. Pa partmen portan ury or	ł	4 Donation 5 Other Specify: EVERGREEN 21. Signature of Funeral Service Atcensed ONA THAN D. HIBN 22. N		7-2011 CON FUNE		NEW JERSEY				
	4		25 BERGENS ST. NI							
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or complications of chronic alcohol abuse Due to (or as a consequence of): Approximate Interval Between Onset and Death Death								
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated								
d ansit	Ĕ	events resulting in death) Last Due to (or as a consequence of):								
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O.O. BO) that the death ored by the att detached for	ڇ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I	23e. Did tob	pacco use contribute to t	the cause of death?				
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Division of Vital Records, P tal or Attending Physician: The law requires I ta dreat death. **I Director: After this certificate has been sign led in by the funeral director, page 2 should be contification.	Сотріете			24a. Was an autops perform	y prior to c ned? death?	topsy findings available completion of cause of s				
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ion ceath.		1 Natural 5 Pending 2 Accident Investigation (Month, Day, Year)	1 Yes 2 No							
Division pital or Atten ours after death teral Director: filled in by the	Certification	3 Suicide 6 Could not be determined (Specific)	t, factory, office building, etc.	28f. Location (St or Town, Sta	reet and Number or Rui ate)	ral Route Number, City				
Hospi 4 hou	. j	4 Homicide (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurr one) 2 Medical Examiner: On the basis of examination and/or investigation	ed at the time, date and place, and on, in my opinion, death occurred at	due to the cause	(s) and manner as state	ed.				
2 1 2 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2	Med -	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon					
		aller Signell Mit	O.C.M.E.		May 19, 2011					
oxens	1	30. Name and address of person who completed cause of death (Item 23a)								
Stat		Melissa Brassell, MD Assistant Medical Examiner 900 W 31. Date filed (Month, Day Year) 37. Registrar's Signature		e, MD 21223	3					
Stat Registra	ar	31. Date filed (Month, Day, Year) MAY 2 6 2011 Registrar's Signature								

State of Maryland / Department of Health and Mental Hygiene [] 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 24 Rosalie Bickford 2011 5:05 Tebbs РМ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death College Manor Lutherville Baltimore If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Months Days Hours Min 82 Director 220-24-9391 Virginia Usual Residence of Decedent show at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits must be notified 28a-f Baltimore Timonium 1 Tes 2 X No Marvland ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a #202 21093 U.S.A. 12300 Rosslare Ridge Road f Health and Mental Hygiene.
item 27 is marked other than "natural", or items
other traumatic event, the Medical Examiner mu death Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. 1 Never Married 2 Married ģ filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 Divorced Completed Specify. Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Representative Health Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Sue Williams Tebbs Douglas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 siment of Health a Mary Sue Bickford/ daughter 517 S. Wolfe Street, Baltimore MD 21231 20a. Method of Disposition 20b. Place of Disposition (Name of per nit. Page 1 a
Der artment of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) May 28, 2011 Timonium, Maryland Dulaney Valley Memorial 21. Signature of Funeral Service License 22. Name and Address of Facility Towson, MD 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition meumone Medical resulting in death) Due to (as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami that the death certificate be executed Due to (or as a consequence of) resulting in death) Last anding physician use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Live Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) atten for u in the past 12 months? Month Pregnant at time of death Dav Year ed by the a detached f 9 Unknown Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, or Attending Physician; The law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown nenendama been 24b Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy 2 4 No 1 Tes 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? assisted 2 🗹 No 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 ther (Specify) After this funeral 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending Natural injury 4 hours after death.

**uneral Director: After the function of Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determin 24 hours Medical within 24 hours to the Fune completed fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 29c. License number 30. Name and address of person who completed cause of death (Item 23a) ype, Print ROSTENBERG 31. Date filed (Month, Day; Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Of		rtificate of Death	Reg.	
	Physicia	n/	1. Decedent's Name (First, Middle, Last) NICHAL L	CARM	PU	2. Date of Death	Day Year 2 A A M
	Medic Examin		4a. Facility Name (if not institution, give street and numbe		b. Lity, Town, or Location of Deat	11/ay 2	4c. County of Death
	Funeral		3429 Gaither Road 5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday)	Windson Mill If Under 1 Year If Under 24 Hrs	8. Date of Birth	Baltimone 9. Birthplace (State or Foreign
	Director		216.28.8658 10M2XF	SO Yrs.	Months Days Hours Min.	(Month, Day, Yea 08 22	Country) MD
	and show d at	tor	Usual Residence of Decedent 10a. State 10b. County Baltimore	10c. City, Town or Loc			10d. Inside City Limits
	e Mary r 28a-f notifie	Director	10e. Street and Number	Wind	SOV MILL 10f. Zip Code	140	1 ☐ Yes 2 🗷 No Citizen of What Country?
	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		3429 Gaither Road		21244	Tug.	USA
10	r death or item niner m	Completed by Funeral	11. Marital Status 12. Was Deceder Armed Force 1 Ves 2 Married 1: Yes 2	nt Ever in U.S. 13. V	Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
215-0036	urs afte tural", o	ted b	3 Widowed 4 Divorced If Yes, Give Year or Dates		1 ☐ Yes 2 XNo Specify:		Specify: Back
215-	72 ho an "nat Medic	mple	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4)	(Give I	dent's Usual Occupation kind of work done during most of wor O NOT use retired)	rking 16b	b. Kind of Business Industry
2	d withir tygiene ther tha nt, the	Be Co	Elementary/Seconday (0-12) College (1-4 of A) 17. Father's Name (First, Middle, Last)	1 3+)	Domestic		Domestic
Maryland	uld be file Mental H narked o	To E	Thomas R. Carney			me (First, Middle, Maid M Williak	
Mary	should be h and Ment 7 is marker traumatic e		19a. Informant's Name/Relationship (Type, Print)	T T	ng Address (Street and Number or		1
	of Healt of Healt fitem 2		Mark A. Smith, Sr./S	20b. Place of Dispo	sition (Name of	Date , 20c	100e MD 21230 c. Location - City or Town, State
Baltimore,	t. Part tmer tant tant jury		1 XBurial 2 ☐ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	Avbutus	Memoria (05)	28 11 I	Paltimore, UD
Bal	permit. Par Departmer Important any injury once.		21. Signature of Funeral Service Licensee C. M.				Letimeral services
			23a. Part 1. Enter the disease, or complications that caus shock, or heart fillure. List only one cause on each	sed the death. Do not ente	er the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or any other cause)	theresca	lerolic CA	diova	bully beath
-	Examiner	-E	Sequentially list conditions, b.		<u> </u>		
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	as a consequence of):			
	ficate be executed g physician and as the burial-transii		that initiated events resulting in death) Last C. Due to (or a	as a consequence of):			
3760	ificate be executed g physician and as the burial-transit	Medical	d				
Box 68	death certific ne attending ed for use as	Physician/N	in the past iz months?	h 2 🗌 Fetal death 3 🗌	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
.O. Be	de ec	hysic	1 Yes 2 No 4 Pregnar 9 Unknown 9 Unknow		other (specify)		
σ.	The law requires that the de ate has been signed by the page 2 should be detached	þ	Part II. Other significant conditions contributing to deat) but not resulting in the u	inderlying cause given in Part I.		co use contribute to the cause of death? 2 No 3 Probably
of Vital Records,	w requi s been 2 should	Completed				24a. Was an	24b. Were autopsy findings available
Rec						autopsy performed 1 🗆 Yes 🏖	
Vital	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	atient 2 - ER/Outpatien	26. Place of Death (Che	ck only one)	DAUGHTER'S OPOTHER (Specify) A MAD
	ing After une		27. Manner of Death 28a. Date of it		28c. Injury at work?	28d. Describe how in	-
Division	tea tor: the	Certificate:		njury - At home, farm, stre	M 1 ☐ Yes 2 ☐ No eet, factory, office		and Number or Rural Route Number,
Οį	Hospital or 24 hours afte Funeral Dir ted filled in		bullaing,	etc. (Specify)		Gity or Town, St	
		Medical		f examination and/or invest		at the time, date and pla	ace, and due to the cause(s) and manner stated.
	To the within To the comple		29b. Signature and title of certifier	nn	29c. License number	77 //1	Date signed (Month, Day, Year)
	,		30. Name and address of person who completed cause o	f death (Item 23a) (Type, P	Print)	A in	106/ Md 2/06/
	Stat		31. Date filed (Month, Day, Year) - 32. F	734 Avi	is d'an Blud	uten Bu	wrip (Nd 406/
	Registra	-	NAV 0 0 2011	1 1	a Kal		

			Please 1	Type or Print in Bla amend item#18, State of Maryland	ack Indelible perFH, g916 Department	Ink Ensure	All Copie	s Are Legit	ole.
			1 - For State Registrar	Otate of Maryland	Certificate of			Reg. No.	1 10///
	Physicia Medic		1. Decedent's Name (First, Middle, Last)	CARNOLO	-,5r.		2. Date of De		3. Time of Death
and the same of	Examir		4a. Facility Name (if not institution, give st	reet and number) MANY	AND 4b. City, Tov	4c. County of	Death		
	Funeral Director		21074 1300 /	7. Age (In yrs. last t	birthday) If Under 1 \ Yrs. Months D	Year If Under 24 Hrs Days Hours Min		th 3. (939	9. Birthplace (State or Foreign Country)
	ryland t-f show ied at	Director	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location Fimore				10d. Inside City Limits 1 ❤️Yes 2 □ No
	ith the Ma 3a or 28a t be notif	ral Dire	10e. Street and Number 3600 W. Fra	Apt		ode		10g. Citizen of Wh	
920	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ed by Funeral		2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	If Yes, specify	t of Hispanic Origin? (S Cuban, Mexican, Puer No Specify:	Specify Yes or No- to Rican, etc.)		American Indian, White, etc. Black
21215-0036	within 72 houn giene. ner than "natu t, the Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secol day (0-12)		life. DO NOT use ret	one during most of wo	orking	Michael Michael	gornery ards
Maryland	ld be filed Mental Hy larked oth atic event	To Be	17. Father's Name (First, Middle, Last) Faward G.	arroll		N	ame (First, Middle,	Maiden Sumame)	mes
_	id 2 should ealth and Me n 27 is mar er traumati		19a. Informant's Name/Relationship (Type		9b. Mailing Address (St	reet and Number or R	Re Ca	er, City or Town, Stat	te, Zip Code) D 21017
Baltimore	0		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)		e of Disposition Name cetery crematoly or other	of place) Obrial 5-	Date	20c. Location - C	ity or Town, State
Balti	permit. Page Department Important: any injury o		21. Signature of Funeral Service Licentee	Greene	22. Net out 2	stress of Pacility G	eene f	useral Ke (21	Services 229)
	Physician/ Medical		23a. Part 1. Error the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)		MAMY EI	dying, such as cardia	c or respiratory ar	PRO AS	Approximate Interval Between Onset and Death
0	cate be executed physician and s the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a consequenc		(EPC -	<i>J-</i> -	<u> </u>	PARCE
. Box 68760	ath certifi attending or use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ic. If yes, outcome of pregnancy 1 Live Birth 2 Fetal de: 4 Pregnant at time of death 9 Unknown				23d. Date of Month	
ls, P.O.	s tha	اج	Part II. Other significant conditions conf	ributing to death but not resultin	g in the underlying caus	se given in Part I.			ute to the cause of death?
3ecor c	The law req cate has bee page 2 shou	Completed					24a. Was auto perfo 1 Yes	psy prid	re autopsy findings available or to completion of cause of ath? Yes 2 \sum No
talF	ician: The certificate ector, pag	Be	25. Was case referred to medical examiner?	espital:		6. Place of Death (Che	-	2 110 12	
of V	g Phys er this eral dir	e: T o	27. Manna of Death	1 ☐ Inpatient 2 ☐ ER/0 28a. Date of injury 28b	Outpatient 3 LI DOA D. Time of 28c. I	4 ∐ Nursing I Injury at		dence 6 Other (Specify)
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day, Year) 28e. Place of Injury - At home, building, etc. (Specify)	М	work? 1 Yes 2 No fice	28f. Location (S		or Rural Route Number,
ă	Hospital or 24 hours afte Funeral Dirested filled in I	Medical C	29a. Certifier 1 Certifying Physic (Check 2 Medical Examine	ian: To the best of my knowledger: On the basis of examination and	e, death occured at the	time, date and place,	and due to the ca	use(s) and manner a	as stated.
	To the h			Practioner: To the best of my kno	owledge, death occurred				er as stated. nonth, Day, Year)
	00		30. Name and address of person who cop	poleted cause of death (Item 23a	i) (Type, Print)	1991	7)	05 125	ion mg
	W Str		KEUWETH 31. Date filed (Month, Day, Year)	32. Registrar's Signature	97 200	TH GREA	IN ST	· Btcii	usic 1.
H	Stat Registra	-	MAY 26 2011 /2.	A bear	1.1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 0 1 |

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		1- For State Registrar		Certificate	of Death		Reg. No.		
Physici Medical Exami		1. Decedent's Name (First, Middle Eddie	Chaney.	, Sr	·	2. Date of Dea Month May 19, 2	Day Year	3. Time of Death 2145 hrs	
		4a. Facility Name (if not institution Harbor Hospital	i, give street and number)		4b. City, Town, or Location of Baltimore	Death	4c. County of Death	1	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Every 103-32-1778 1 Am 2 F For Months Days Hours Min. March 20, 1942							
id bow any	_	Usual Residence of Decedent 10a. State 10b. County	sla "	0c. City, Town or L	altimore		,	10d. Inside City Limits 1 Ves 2 No	
ith the Maryland 23a or 28a-f sho notified at once	Director	10e. Street end Number 2232 West	Lexinator	St	10f. Zip Code 2 1 2 2 3		10g. Citizen of What Cou	•	
after death with the Maryland al", or items 23a or 28a-f she inst must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Ma	1 Yes 2	No	Was Decedent of Hispanic Drigin If Yes, specify Cuban, Mexican, I		14. Race - Amer White, etc.	ican Indian, Black,	
2 hours	eted by	3 Widowed 4 Divo 15. Decedent's Education (Spec Elementary/Secondary (0-12)	rced If Yes, Give Year or Dates: ify only highest grade compl College (1-4 or 5+)	leted) 16a. Dece	Yes 2 No specify: edent's Usual Occupation (Give king g most of working life. DO NOT u		Specify: 16b. Kind of Business/	,	
21215-0036 uld be filed within 72 ho Mental Hygiene. marked other than "na	Completed	17. Father's Name (First, Middle, I	Last)			Name (First, Middle,	Transp Maiden Surname)	oration	
2121 hould be fill and Mental F is marked rite event, i	To Be (19a. Informant's Name/Relationsh		19b. Ma		er or Rural Route Nu	haney mber, City or Town, State	1 10	
ages I and 2 should not of Health and Note: If item 27 is not other traumatie		20a. Method of Disposition 1 Burial 2 Cremation	3 Removal from State	20b. Place of Dis	position (Name of cemetery, rother place)	HORK F	20c. Location - City or	. 3	
Baltimore, permit. Pages la Department of He Important: If its injury or other ti		4 Donation 5 Other Special Signer e of Funeral Serv	ecify:/	Metr	2. Name and Address of Facility	5/24/2011	Baltir Euxex	noce, MD	
Physician /Medical	- 53	23 Fart I. Enter the disease, or of failure. List only one cause of	complications that caused the each line.	e feath. Do not ent	er the mode of dying, such as car	rd c or respirato y an	est, shock, or heart	Approximate Interval Between Onset and	
xaminer	1	Immediate Cause (Final disease or condition resulting in death)	a. Multiple II Due to (or as a consequ	njuries uence of):	-			Death	
	I Examiner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Cause. Enter Underlying Cause Chiese or injury that initiated C.							
cuted and transit		(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent)						
760, icate be executed physician and the burial - transit	Medica	▼ UNPENDED IF FEMALE:			per me,g916 6-9)-11 sm	Too Division		
DX 68 ath certif attending or use as	clan/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkr	4 Pregnant at tim	2 🗌	Fetal death 3 Ectopic p Other (Specify)	pregnancy	23d. Date of delivery Month	/ Day Year	
i, P.O. Be ires that the de signed by the be detached f	2	Part II. Other significant condition		out not resulting in the	ne underlying cause given in Part		obacco use contribute to	_	
of Vital Records, ng Physician: The law requir ther this certificate has been si meral director, page 2 should be	Completed						prior to comped? prior to comped?	topsy findings available completion of cause of	
Vital Reco ysician: The law his certificate has director, page 2 s	Be Co	25. Was case referred to medical examiner?			26. Place of Death (C	1 Yes	2 No 1 ✓ Ye	es 2 No	
f Vit Physici er this c	10	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpat		Nursing Home 5	Residence 6 Other	:	
Division of ' Lal or Attending Ph Is after death. Al Director: After t led in by the funeral	ertification:	1 Natural 5 Pendir	ng fd 5-19-	11 fd 9:	30 pm 1 Yes 2 x N	Subject	pedestriar vehicle	struck by	
Divi	ertifi	3 Suicide 6 Could 4 Homicide	not be	oadway	treet, factory, office building, etc.	or Town, S	Street and Number or Ru State) 3100 Sout ore,Md.	h Hanover St	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical C				ccurred at the time, date and place igation, in my opinion, death occu				
	Ž	29b. Signature and title of certifier	Ki a Th	2 auro	29c. License number O.C.M.E.	OCME	29d. Date signed (Mo) May 20, 2011	nth, Day, Year)	
		30. Name and address of person w Theodore M. King, Jr.,	MD. Assistant Med	dical Examiner	900 W. Baltimore Stree	et, Baltimore, Mi	21223		
St Regist		31. Date filed (Mohth, Day, Year)	. Registrar's	Signature	Kel				

State Registrar

3altimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 2:45p M Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 2924 Parkway Baltimore Liberty Apt Dundalk 7. Age (In yrs. last birthday) 55 yrs Social Security Number Sex ∤ M 2 □ If Under 1 Year If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) 8. Date of Birth 216-66-3530 Months Days Hours Min Director 0271471956 MD Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 2924 Liberty Parkway Apt D 21222 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? ð 1 X Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Security Guard Hospital 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Dorothy Gaither t. Page 1 and 2 should be fill thent of Health and Mental rant; If item 27 is marked or Edward Caricofe traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorie Caricofe Sister S. Ellwood Ave Baltimore MD 21224 other t Department of Healt Important; If item 2 any injury or other Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Atlantic Crem 05/25/11 Glen Burnie MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licens 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllen P.A. 7090 RidgeRD Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Corancy disease or condition resulting in death) Medical Due to (or as a co sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Tes 24b. Were autopsy findings available 24a, Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s prior to completion death? autons performed Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 100 Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 5 Pending injury ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nayse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one Signature and tit icense number 2011 MD ame and address completed cause of death (Item 23a) (Type, Print) S200 trasten 31. Date filed (Month, Day, Year) sistrar's Signature State Registrar DHMH 17 Rev 7/2009

ORIGINAL

			_	Pleas	e Type or Pri State of M				K. Ensure A Health and I					10701
			For State Registrar				Cei	tificate of L	Death		Reg. N			16781
Z	Physicia	ın/	1. Decedent's Name		,					2. Date of De Month		2011	⁄ear	3. Time of Death
A	Medic Examir		Lillian Viola Dinkelkamp 4a. Facility Name (if not institution, give street and number)					4b. City, Town, o	r Location of Death	May 2	$\overline{}$	2011 lc. County of	Death	1:45 A. M
19	/		Oak Cre					Baltim				Balt		e
-:	Funeral Director		5. Social Security Nu. 217–14–5		Sex 7. Ag 1 ☐ M 2 🔀 F	je (<i>In yr</i> s. <i>I</i> a	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Dec. 1	rth av, Year	921	9. Birthpl Counti	ace (State or Foreign
		L	Usual Residence of							Dec. 1	4,	L941]_		"Maryland
-	aryland a-f sh ified a	Director	10a. State Maryland	Harfo	rd		r, Town or Lo						10	od. Inside City Limits
5/24/11	the M a or 28 se noti	I Dir	10e. Street and Num		ıu	Eu	gewood	10f. Zip Code			10g. (Citizen of Wh	at Count	
10	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	617 Lace	ewood Dr				21040				JSA		
~ 9	er dea or iter miner	by Fu	11. Marital Status1 \(\sum \) Never Marrie	ed 2 Married	12. Was Decedent I Armed Forces? 1 Yes 2 🛣			Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	-	14. Race - Black,	America White, et	
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7 5	72 ho in "nai Medica	Completed			grade completed)		(Give i	lent's Usual Occup kind of work done o O NOT use retired)	ation during most of work	king	16b.	Kind of Busi	ness Indi	ustry
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D_{iN} $k \in IK_{AMP}$ Maryland 21215-0036	ntal Hy red oth	To Be	17. Father's Name (F Stanley						18. Mother's Nam					
aryle	nould band Me s mark	Ì	19a. Informant's Na	-		-	19b. Mailir	a Address (Street a	Mary A	Lice Was al Route Numbe			e. Zip Co	nde)
	nd 2 sh ealth a m 27 is ier trai		Vivian H		Sister	13	1							. MD 21234
illi⊕N altimore,	ge 1 an at of H : If item or oth		20a. Method of Disp 1 Burial 2	Cremation 3	☐ Removal from State	ce	ace of Dispo emetery, cren	sition (Name of natory or other plac	:e)	Date		Location - C		
iltim	nit. Pa artmer ortant injury		4 ☐ Donation 21. Signatur of Fun		#Intombment	t Bel							_	aryland
7	permir Depar Impor any in		1317 Cokesbury Road, Abingdon, Maryland 21009											
			23a. Part 1. Enter the shock, or heart	ne disease, or controlly	nplications that caused the cause on each line	the death	. Do not ente	r the mode of dyin	g, such as cardiac	or respiratory ar	rest,		3 10 7 7	Approximate Interval Between
	Physician/ Medical		Immediate Cause (F disease or condition resulting in death)		a. Due to (or as	<u> 45</u>	C/ \/_)						Onset and Death
-	Examiner		Sequentially list services	aditions	bue to (or as	a conseque	siice oi).							
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687(ertificat ding ph	/Mec	IF FEMALE:		23c. If yes, outcome	of pregnan	IPV							
Division of Vital Records, P.O. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☑	nonths?	1 ☐ Live Birth 4 ☐ Pregnant a	2 🗌 Fetal	death 3	Ectopic pregnanc Other (specify)	y			23d. Date of Month		y Day Year
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Ф.	res tha signed	ρ	Part II. Other signific	cant conditions	contributing to death b	ut not resu	iting in the u	nderlying cause giv	en in Part I.					cause of death?
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of V	Physical Chiral Caral Chiral	은 .	1 Yes 2 27. Manner of Death		1 Inpatie	ry 2	R/Outpatien 28b. Time of		4 Nursing Ho	ome 5 Resid			Specify)	
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	spital hours a neral [29a. Certifier 1	Certifying Ph	ysician: To the best of	my knowle	dge, death o	ccured at the time,	date and place, ar	nd due to the ca	use(s) a	ınd manner a	s stated.	
	the Ho nin 24 I the Fu npleted	Medical	(Check 2 l only one) 3 [niner: On the basis of ex rse Practioner: To the	xamination a	and/or investi	gation, in my opinio	n, death occurred a	t the time, date a	and plac	e, and due to	the caus	e(s) and manner stated. ed.
	with con		29b. Signature and ti	itle of certifier	h	001	∧	29c. License				ate signed (A		
	15	}	30. Name and addres	ss of person who	completed cause of de	eath (Item 2	23a) (Type, Pi		R0673	43 HRKVII	•	2-2	4-	2011
	1.0		Alice	M BRA	725CR 5	2200	WAL		61 PF	ARKVII	10,	MD.	2	12.34
	Stat Registra	-	31. Date filed (Month,	6 2011	32. Registra	s Signat	2 Kel			,				1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8137PM Medical Facility Name (if not institution, give street and number City, Town or Location of Death 4c. County of Death **Examiner** Medica timore Social Security Number If Under 1 Year 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours (Month, Day, Director 7-66-4483 Usual Residence of Decedent 28a-f shov Director 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant of Health and marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits 1 ☐ Yes 2√ No MD Cecil Perryville 10e. Street and Number 10g. Citizen of What Country? Funeral I 5443 Pulaski Hwy Apt 21903 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 - Widowed 4 Divorced Specify: Completed Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Housekeeping Aide State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bernard Dorsey Sr. Mary Ellen Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Tasha Dorsey-Daughter</u> Louise Ave, Baltimore, Md 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1
Department of Important: If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison For<u>est Vet</u> 6/1/201 Owings Mills, 22. Name and Address of Facility
March F/H West
4300 Wabash Av Signature Funeral Service Licen Ave. Baltimore, md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Cirrhosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed partocelly (AR CARCINOMA 1 Yes 2 Mo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: ဥ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 Tes 2 🗆 No Investigation 3 Suicide 4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (frem 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DEXTER Physician/ Month 2011 15-40 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE RANDALLSTOWN NORTHWEST HOSPITAL CENTER Social Security Number **Funeral** 6. Sex '. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days 1 D M 2 X F Hours 85 099-22-7112 04/28/1926 Country) **Director** NY Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE BALTIMORE 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21207 USA 6817 FOX MEADOW ROAD 11. Marital Status . Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Ongin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 2 X No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE If Yes, Give "natural", 3 X Widowed 4 □ Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME traumatic event, the HOMEMAKER should be filed with and Mental Hygien 7 is marked other tl Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ SAMUEL WEISBERG **GERTRUDE** 19a. Informant's Name/Relationship (Type, Print)
BARRY DEXTER/SON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3100 LABYRINTH ROAD, BALTIMORE, MD 21208 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date MIKRO KODESH BETH ISRAEI 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 05/25/2011 BALTIMORE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature of Funeral Service Licen 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on a cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ OBSTRUCTIVE LING HROMC disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Dav Year ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FIREILLATION ATRIAL CEREBROUASCULIA Records, 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available DIS GASE autopsy prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Yes 2 XN Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 XNo ၉ 1 Ninpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Hospital or Attending I (Month, Day, Year) 2 Accident 1 Natural 5 Pending 1 Yes 2 No Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Funeral Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier MO 22 2011 30. Name and address of peron who completed cause of death (Item 23a) (Type, Print) NORTH WEST HOSPITAZ RANGARA DAN I KAMASWAM 31. Date filed (Month, Day, State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 15784 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certific	ate of Death		R	eg. No.		
Physicia Medical Examir		1. Decedent's Name (First, Middle, Alan Carl E	ifert				2. Date of Dea Month May 21, 2	Day Year 011	3. Time of Death 0730 hrs	
		4a. Facility Name (if not institution, Upper Chesapeake Me	dical Center		Bel Air	wn, or Location		4c. County of Dea Harford		
Funeral Director		220-25-4393	7. Age (II	n yrs. last bi	rthday) If Under Months Yrs.	1 Year If Und Days Hour	e Min	er 7,1989		
yland •-f show any once.	tor	Usual Residence of Decedent 10a. State 10b. County Md . H 10e. Street end Number	larford 10	c. City, Town	n or Location BelAir	odo.		On Citizen of What Co	10d. Inside City Limits 1 Yes 2 No	
th the Maryland 23a or 28a-f sho notified at once,	I Director	901 Peppard Dr				2101	4	0g. Citizen of What Co USA		
's after death wi	by Funeral	11. Mantal Status 1 Never Married 2 Marr 3 Widowed 4 Divor 15. Decedent's Education (Specif	1 Yes 2 No rorced If Yes, Give Yeer or Dates:			Cuban, Mexicai No specify		- 14. Race - Ame White, etc. Specify:	White	
5-0036 led within 72 hour tygiene. other than "nati	Completed	Elementary/Secondary (0-12) 12th	College (1-4 or 5+)	100.	during most of worki			Auto Deta	,	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medical	8	17. Father's Name (First, Middle, L. Norman Eifert				Ma	r's Name (First, Middle, M ry M. Zack			
and 2 should lealth and M tem 27 is m:	욘	19a. Informant's Name/Relationship Norman Eifert	(Type, Print) Fat	her	901 Peppa	rd Driv		Md. 21014	11	
Baltimore, MI permit. Pages I and 2 s Department of Health a Important: If item 27		20a. Method of Disposition 1 Burial 2 X Cremation 4 Donation 5 Other Spec	cify:	crema	of Disposition (Name story or other place) atic Crema	tory	Date 5-25.2011	Glen Burn		
	I	21. Sundiure of Juneral Service Li			22. Name and A	air Roa	d Notting	k FuneralH ham, Md. 2	1236	
Physician /Medical Examiner		23a. Part I. Enter the disease, or failure. List only one cause or Immediate Cause (Final disease or condition resulting in death)	n each line.	intoxi		dying, such as o	cardiac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death	
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease of Unity that instead								
executed an and al - transit		events resulting in death) Last X UNPENDED	Due to (or as a conseque d AMENDED 23a, 2	,	-f.per me.	2915 6-	-3-11 sm			
certific	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 23d. Date of delivery Month Day Year 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown 9 Unknown								
P.O. I see that the gned by the detacher	ক্র	Part II. Other significant condition	ns contributing to death bu	t not resultir	ng in the underlying ca	ause given in Pa		bacco use contribute to		
Division of Vital Records, P.O. I allow requires that the rs after death. al Director: After this certificate has been signed by the din by the fineral director, page 2 should be detached.	Completed						24a. Was a autop: perfor	sy prior to med? death?	utopsy findings available completion of cause of les 2 No	
Vital ysician: his certi	m̃	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 P ER/O	26. Outpatient 3 DO/	Othor -	(Check only one) Nursing Home 5	Residence 6 Othe	er:	
ion of Vita trending Physicia leath. tor: After this ce the funeral direct	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investig	28a. Date of Injury (Month, Dey,Year)	28b.	Time of Injury 286	: Injury at Work		ow injury occurred		
file on	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, Cit or Town, State) 901 Peppare Dr. Bel Air, Md.								
To the Hosp within 24 hos To the Func completely fi	G		sician: To the best of my knoner:On the basis of examination and manner stated.							
		29b. Signature and title of certifier 20b. Name and address of person with	me (), MD	(Itam 23a)		icense number D.C.M.E.		29d. Date signed (Mo	onth, Day,Year)	
		Melissa Brassell, MD	Assistant Medical Ex	aminer	900 W. Baltimo	re Street, B	altimore, MD 2122	3		
Registr	ar	31. Date filed (Month, Day, Year)	32. Pegistrar's S	1	Sall I					
DHMH 17 Rev 1/200	וע	OCME		OF	KIGINAL					

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene 2 1 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Leona Marie Farrow Physician/ 9:50 A M May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel **Examiner** Annapolis Heritage Harbour Health & Rehab 9. Birthplace (State or Foreign Country) MD 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 212-10-5415 Days 1 □ M 2 😿 F 1 1 / 0 5 / 1 9 1 9 92 **Director** Usual Residence of Decedent 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Annapolis MD Anne Arundel 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2700 South Haven Road USA 21401 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ould be filed within 72 hours after of Mental Hygiene. marked other than "natural", or ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 Yes, Give 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 □ Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) event, the 8 Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Agata permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve Peter Batrowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melisa Claar/Granddaughter 403 Ben Oaks Drive West, Severna Park, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Final Journey crem. 5/28/2011 Woodbine, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 21. Signature of Funeral Service Licensee Dorota Marshall llaishall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/) Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ To the Hospital or Attending Physician: The law requires that the death or within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attents. in the past 12 months? Month Year 4 ☐ Pregnant at time of death g ☐ Unknown 2 🔀 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Nursing Home 5 - Residence 6 - Other (Specify) 2 No ပ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29c. License number person who completed cause of death (Item 23a) (Type, Print) State Registrar

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Fishe **Physician** 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 170-36-0443 Age (In yrs. last birthday) **Funeral** Months Days 1X M/ 2 F 67 PΑ 05/22/1944 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Winter Park 1X Yes 2 ☐ No Director FL Orange 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code USA 32789 Interlachen Ave, Apt101 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ★ Yes 2 □ No If Yes, Give Year or Dates: Army Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Retail Sales Manager 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Lillian Stephens Be Cloyd Fishel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Hural Houte Number, Oily of Tourn, Sans, Winter Pa 100 S. Interlachen Ave., Apt.101, Winter Pa FL 32789 Judy A. Fishel / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 👿 Cremation 3 ☐ Removal from State 5/28/2011 4 Donation 5 Other (Specify) Final journey crem. Woodbine, MD 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21. Signature of Funeral Service Licensee Dorota Marshall aushall 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, If any, reading a firm ediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra resulting in death) Last Due to (or as a consequence of) g physician a Division of Vital Records, P.O. Box 68760, Physician/Medical attending IF FEMALE use ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 - Fetal death 3 Ectopic pregnancy Day Month Year for in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 9 Unknown the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ate has been signed page 2 should be de þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 □ No 1 Yes Yes certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: Hospital: 1 Yes 2 No 4 - Nursing Home Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) ၉ this within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral or 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? Certification: (Month, Day Injury 5 Pending investigation Natural M 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 4x11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 KONER MAN MONIC 31. Date filed (Month, Day, Year) State MAY 26 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Jane P. Fleming A_{\bullet}^{M} 24 2011 May 9:28 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Broadmead Hunt Valley Baltimore 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) St. Paul, Minnesota If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 200 F 476-20-3180 89 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show 10a. State Department of Health and Mental Hygiene. Important; if item 271s or 28arf show Important; if item 271s marked other than "natural", or items 23a or 28arf show important; if item 271s marked other traumatic event, item Marical Exaction of the marked once. Maryland Baltimore Hunt Valley 1 ☐ Yes 2 No Director 10f. Zip Code 10g Citizen of What Country? United States 10e. Street and Number 21030 13801 York Road Apt. G3 of America Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ⊠No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2√2√No Specify white **À** Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and 2 should be filed within ealth and Mental Hygiene.
n 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Non-Profit Director 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas A. Phillips Lorena Harrison P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 98 Kents Store, Virginia 23084 Mr. Gary P. Fleming/son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral
Chapel-Bel Air ^{Date} 25, 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2011 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 21. Signature of Juneal Service Licens Peaceful AlternativesFuneral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transi Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate ! 2 **D**No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 211NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manne of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 L atural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident the within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature ed (Month, Day, Year) State 6 2011 Registrar

DHMH 17 Rev 1/2001

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Dr		vith To th		29b. Signature and title of certifier	Render V	w	L	icense number			9d. Date signed (Mont	2011	
•	2)		30. Name and address of person who have a filed (Month, Day, Year)	o completed cause of death (II	tem 23a) (Type,	Print) 3310	1 54 413	ا ما	Baltin	more Mary	6,5	
		Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's 32	Willed.							

Division or Vital Records. P.O. Box 68760.

Saltimore. Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year) MAY 26 2011

Amy S. Johnson

30. Name and address of person who

3. Registrar's Signature

pleted cause of death (Item 23a) (Type, Print)

D58928

305 10th Street, Suite 101, Pocomoke City, Md. 21851

05/23/11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Clifford A . Hutchinson Medical 05 2011 25p 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchirst Hospice Baltimore Towson 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 1 XM 2 - F Days Hours Min. Director Yrs. 229-48-6240 02 17 Usual Residence of Decedent 28a-f shov 10a. State notified at Director 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Owings Mills 1 Yes 2 No 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 4534 Donatella Square 21117 U.S.A. within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural" 3 Divorced Specify: Completed Black Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 2th grade Tractor Trailer Driver II.P Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of traumatic even မ 1 and 2 should be of Health and Ments Eugene Hutchinson Fannie Macklin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trauonce. 21117 Kelly Henso 20a. Method of Disposition Henson-Niece Baltimore, 34 Donatella Owings Mills, M 20c. Location - City or Town, State Square, 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Cathedral 5/27/2011 Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician meimonia disease or condition resulting in death) welk Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): the attending physician and hed for use as the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Demen 1 Yes 2 V 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate has autopsy performed? Yes 2: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No 잍 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICO 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Affer 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours atter com...he Funeral Director: Aff work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6
Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOD 7063 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pater 670 Charles 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 6 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY Physician/ 12.55 PM Leroy M. Hellmig, Sr. 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HOSPITAL BALTIMORE N/A ST. AGNES 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Mar. 4, 1924 1 XM 2 □ F 87 Hours Min. Commary land 216-16-1812 Director Usual Residence of Decedent r 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes X No Baltimore Arbutus 10e. Street and Number items 23a or ner must be n ō 10f. Zip Code 10g. Citizen of What Country? Funeral 21227 United States 1214 North Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 △ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ural", or iter Black, White, etc. 1 Never Married 2 Married þ filed within 72 hours after Maryland 21215-0036 1 ☐ Yes XX No Specify. Specify: White "natural" Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore County Police Officer 12 alth and Mental Hygie
27 is marked other
r traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Ethel Mary Hall Otto Hugo Hellmig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1214 North Avenue, Arbutus, MD 21227 Health tem 27 Terry Lynn Hellmig - Daughter item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Loudon Park Cemetery: 5-28-2011 Baltimore, MD Funeral Service Lice 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. terval Between nset and Death 24 HOULS shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ SEPSIS disease or condition : Medical resulting in death) Due to (or as a consequence of) **Examiner** PNEUMONIA Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence oi) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be 68760 IF FEMALE use 23b. Was decedent pregnant 23d. Date of delivery Box Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Dav the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be SARCOIDOSIS Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No 1 ☐ Yes 2 🗶 No ours after death.

eral Director: After this certific filled in by the funeral director, Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: မ 1XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined 24 hours Medical To the Hosp within 24 hou To the Funer completed fil 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical examiner: On the basis of examination and on investigation, in my spanish and state and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVENUE BALTIMORE KATHERINE 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

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State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month AMES 5:55 AM 201 05 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ARUNDEL MEDICAL ANNAPOLIS ANNE ARUNDEL CENTO If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 2/20/1955 463-08-1482 **Director** Usual Residence of Decedent shov 10a. State 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No MD Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21037 438 Birch Drive permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes X No Specify: Completed 3 Widowed 4 X Divorced Specify. Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cell Phones Sales Representative Be 18. Mother's Name (First, Middle, Maiden Surname)
Mary Davis 17. Father's Name (First, Middle, Last) George Harmon 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 431 S. Sabrina Mesa AZ 85208 Michelle Harmon-Ebersole 431 S. Sabrina Mesa AZ 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State Atlantic Crem 05/26/11 Glen Burnie MD 4 Donation 5 Other (Specify) 21. Signature 22. Name and Address of FacilitSimplicity Crem & Fun Serv of Funeral Service License ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final HEPA Physician/ TIC CIRRHOSIS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter ondenying Cause (Disease or iinjury Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the aid be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nerform 2 🗆 No Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 \sum Yes 2 No Other: 2 1. Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? injury 2 🗌 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \square Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated соmpleted (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 06675 2011 npleted cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dec t's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Ones eenie /Medical ame (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner bble Baltimore 8. Date of Birth Month, Day, 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday **Funeral** 1 □ M 2 🔀 345-62-9283 Usual Residence of Decedent Carolina Director death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits show ms 23a or 28a-f shov 1 ☐ Yes 2 No Funeral Director saltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items, 11. Marital Status permit, Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Experimen 1 Never Married 2 Married 21215-0036 1 ☐ Yes 3 ☑ No Specify. ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surnar Maryland Father's Name (First, Middle, Last) Be 11550N 19a. Informant's Name/Relationship (Type Printeshoud) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Lip Code) MD21093 BiShop Lo 20a. Method of Disposition IMORIUM 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition cemetery, crematory 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ⊟Other (Specify) Itimore 21. Signature of Euneral Service 23a. Part1, nter the disease, or complications that caused the death. Do not enter the mode of d shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Arterioscleso disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed and Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Hospital or Attending Physician; The certificate 1 □Yes 2 No 1 ☐ Yes 2 No Be (25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death filled in by the 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours are To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. The me and address of person who completed cause of danth (Item 2 a) (Type, Print) 60 6 15/mb 31. Date filed (Month, Day, State MAY 26 2011 Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 4:15 AM Charlotte Agnes Jones May 22, 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rosedale Franklin Square Hospital Center Bultimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 03-12-1921 Birthplace (State or Foreign Country)
 MD 7. Age (In vrs. last birthday **Funeral** Days 1 □ M 2 💢 F 90 **Director** 216-12-6078 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f sho Director 1 ☐Yes 2 X No MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800 Walther Blvd. #2003 21234 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces' 1 □Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No \$ Specify: Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if item 27 is marked oth any linjury or other traumatic event sines. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Carroll Dunn Marie E. Hubbard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1115 Valewood Rd Towson, MD 21286 Judith A. Kelly (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial , 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 05-27-2011 Parkville, MD 22. Name and Address of Facility Schimunek Funeral Home of BelAir of Funeral Service Licensee 21. Signature Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician chronic obstructive resulting in death) /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spec/fy) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ko Hanti' (M.D. D69194 MAY, 22, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Kottarathil, M.D. Franklin Square Drive Bultimore MD 21237 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 26 2011 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 11:47 a^M Barbara Louise Kellagher May 2011 Medical 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Ye Months Hours Min. West Virginia 1928 Director 218-26-3591 82 Oct. Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 1 Yes 2 No Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 must be 23a Funeral 2214 Rosewood Drive 21040 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, rral", or iten I Examiner i Armed Forces Black, White, etc. 1 Never Married 2 Married þ 1 X Yes 2 ☐ No If Yes, Give 21215-0036 1 ☐ Yes 2 X No Specify: than "natural", 3 Divorced 4 Divorced Completed White Year or Dates event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) and Mental Hygiene. Elementary/Seconday (0-12) Registered Nurse Health Care Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မှ George Anthony Stolze Dorothy (unk) Zitsmann traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health 27 2214 Rosewood Drive, Edgewood, MD 21040 Robert Kellagher / Husband t: If item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ₹ cemetery, crematory or other place) Page 1 1 🛣 Burial 2 ☐ Cremation 3 ☐ Removal from State Important: I any injury o Bel Air Memorial Gdns 5-27-11 4 Donation 5 Other (Specify) Bel Air, Maryland 21. Signatur of Funeral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SHOCK Ph_sician/ EPTIC disease or condition resulting in death) Medical Due to (or as a sequence of) Examiner SHOCK 2 11 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or linjury AWTE 2_ the burial-trar that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): 2 019 ٤١ GSTROIMY. IF FEMALE 23c. If yes, outcome of pregnancy
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1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by should be o 2 → No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has r autopsy performed? ge 2 or Attending Physician: T e this certificate 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2. No Other: 1 🗌 Yes 1. Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director; After (Month, Day, Year) 1. Natural 5 Pending work? 2 🗌 No М ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of ce 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mo 500 21014 State Registrar

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SIOI	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicii compieted filled in by the funeral director, page 2 should be detached for use as the bu	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Ru							mber or Ru	ıral Route Number,	
DIVI	rs affe al Dire led in t			building, e	tc. (Specify)				City or Tov			
Hospi	24 hou Funer sted fill	Medical	(Check 2 Medical Ex	hysician: To the best o aminer: On the basis of	examination	and/or inves	tigation, in my opin	ion, death occ	curred at the time, date a	ind place, and	due to the	cause(s) and manner stated.
To the	within To the comple	Ž	only one) 3 L Certifying N 29b. Signature and title of certifier	lurse Practioner: To the	e pest of my	knowledge,	29c. Licens		and place, and due to th	e cause(s) and 29d. Date si		
	21-0		▶ Namilé Su	/ 1	385			-000	0	May	22,	2011
			30. Name and address of person w	ah, MBB		23a) (Type, I		lal o	f Baltim	nne		
	Sta		31. Date filed (Month, Day, Year)		rar's Signat		11.02		1			
	Registr	ar	MAI 20 ZUII	enun vo.	7	Ste Sight						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 20, 20°Y1 8:10 а м Ke1ch Catherine Carole Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Baltimore **Examiner** Towson Gilchrist Hospice Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Septh, Day Year 1941 1 M 2 X F 220-38-8493 69 MarwTand Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 X Yes 2 No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with USA 21230 2908 Mallview Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc Completed by 1 Never Married 2 Married be filed within 72 hours after ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 H No Specify: White If Yes. Give Specify: 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Textile Company Receptionist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other traumations. မ Μ. Batz Catherine Rumpf Car1 Herman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7213 Downing Ct., Clarksville, MD 21029 Michele Hayden (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Crestlawn Mem. Grus. Marriottsville, MD 5/23/11 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ AMCEN Ö disease or condition resulting in death) wonth Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Physician/Medical Examiner Due to jor as a conse uence of cause. Enter Underlying ng physician and as the burial-transit Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 IF FEMALE: attendi nse 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 mpnths?
1 Yes 2 No Month Year 5 Other (specify) Day Pregnant at time of death sate has been signed by the a page 2 should be detached for Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 **N**0 မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my pointed, death occurred at the time. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier

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State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

angela King	State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No.								
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year								
	4a. Facility Name (if not institution, give street and number) Johns Hopkins Hospital N.C.C.U 4b. City, Town, or Location of Death Baltimore	_							
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) German	ונ							
v any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit								
Maryland 28a-f show d at once. ector	MD Anne Arundel Pasadena 1 Yes 2 X N 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	ю							
with the Maryland ns 23a or 28a-f sho be notified at once sral Director									
72 hours after death with the Maryland natural", or items 23a or 28a-f she al Examiner must be notified at once letted by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Yes 2 No 1 No 1 Yes 2 No 1								
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5-0036 led within 72 hours after Hygiene. the Medical Examiner Completed by 1	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)								
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica fo Be Comple	12 Retail Sales Dollar Tree Stor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	: 6							
21215 uld be file Mental H marked or c event, til	Glen Martin Landis Penelope Jean Peoples								
	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 236 Inlet Dr. Pasadena, MD 21122								
2 7 9 7	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 X Burial 2 Cremation 3 Removal from State crematory or other place) 20c. Location - City or Town, State								
Baltimore, emit. Pages I a Department of He important: If ite	4 Donation 5 Other Specify: Holy Cross Cem 5/27/11 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility C. J. Consco. Funeral Homo. P.A.	_							
Depa Depa Impe	169 Riviera Drive Pasadena, MD 21122	2							
Physician // // // // // // // // // // // // //	23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interv								
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Intracerebral Hemorrhage Due to (or as a consequence of):	_							
Je.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
red No.	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	_							
Day see see is in	d. X UNPENDED AMENDED 23a,pt.II,27,per me,g916 6-29-11 sm	-							
760, Teate be to the buricate	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year	_							
n of Vital Records, P.O. Box 6876(ding Physician: The law requires that the death certificate h. After this certificate has been signed by the attending physe funeral director, page 2 should be detached for use as the boom; To Be Completed by Physician/Me	past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year								
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s, P.O. uires that the nigned by Id be detack	Hypertensive Cardiovascular Disease, Cocaine Use 1 Yes 2 No 3 Probably 4 Unknown 1 24a. Was an 124b. Were autopsy findings availab	_							
Records, The law requires firete has been signage 2 should be Completed	autopsy performed? death?	f							
Vital Rec ysician: The l his certificate l director, page		_							
F Vital Physician r this certi	1 Yes 2 No 1 inpatient 2 EXOutpatient 3 DOA 4 Nursing Home 5 Residence 5 One.	_							
ion of tending Pheeath. Inc. After the funeral the funeral attion; Tation	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No								
Division of Vital Records, To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should b Medical Certification: To Be Completee	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, Ci or Town, State)								
To the Hospi within 24 hou To the Funer completely fil	293 Leπiner □								
To with		_							
	The dove W. King TRy u. S. O.C.M.E. OCME May 25, 2011	_							
rend.	Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223								
State Registra	WAY 26 2011 Brown & Backs								
DHMH 17 Rev 1/2001	ORIGINAL								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARGARET LANG ^D2011 Physician/ MAY 22 11:15PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOWARD **FLICOIT CITY** ELLICOPT CITY REPABILITATION CENTER Social Security Number Age (In yrs. last birthday, 93 yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 218-01-9923 1 M 2 X Months Days Hours Min. 4-5-1918 Director VIRGINIA Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the NACLES CO. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director HIGHLANDTOWN 1 XYes 2 □ No BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21224 U.S.A 1120 S. DECKER AVENUE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14 Bace - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) PAYROLL CLERK GENERAL MOTORS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
JULIA (KISSNER PEZOLD ၀ HENRY 0. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street 1120 S. DEC s (Street and Number or Rural Route Number, City or Town, State, Zip Code) DECKER AVE BALTIMORE, MD 21224 MICHAEL LANG/SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from St CARDENS OF FAITH CEMETERY MAY 26, 2011 BALTIMORE, MD 4 Donation Statement (Specify ENTOMEMENT) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME . Signature of Funeral Service Licenses 1211 CHESACO AVENUE ROSEDALE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Medical Due to (or as a consequence of) Examiner ADVANCED DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛛 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy perform Director: After this certificate 2 🔀 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 □ No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred **X**Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, within 24 hours after To the Funeral Dire City or Town, State) 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Fractioner: To the best of my knowledge, d at the time, date and place, and due to th 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 35082 Mb 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

-109

32. Registrar's Signature

RAMESH

31. Date filed (Month, Day, Year)

BackRiver Neck Road, Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4:40 A M Janice Catherine Lewis May 24, 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u>Upper Chesapeake Medical Center</u> Harford Bel Air Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Days Year) 1944 Maryland Hours Feb. 18, Director 219-42-1717 67 Usual Residence of Decedent shov 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 ☐ Yes 2 X No Maryland Harford Bel Air ò 10e. Street and Number 10f. Zip Code and Mental Hygiene. is marked other than "natural", or items 23a or aumatic event, the Medical Examiner must be i 10g. Citizen of What Country? Funeral 2917 Pemwood Ct. 21015 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married ☐ Yes 2 ☐XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Homemaker</u> Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Jennie Catherine Bickford Williard Ellmon Otto Sr. 102/42/90 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trai Brian Lee Lewis / Son 711 Cagney Ct., Bel Air, Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp 5-26-2011 Towson, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. ase, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final SEVERE SEPOIS FROM Ph sician/ LOSTRIOIA DIFFICILE COLITI disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami sician and burial-trans Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 ding p. IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death Dav Year 2 🗌 No 9 Unknown 9 Unknown P.O. Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 9 HEN, CVA, PVD, DEPRESSION Division of Vital Records, 1 ☐ Yes 2 D.No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform Yes 2 No 1 Tes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 Yes 2 No hours after death uneral Director: A ed filled in by the f Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number D0008014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 UPPER CHESAPEAKE DRIVE BELAIR MP 21014 NASRIN HUO, MD 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

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FINIS ANIOR

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0 Medical **Examiner** 4a. Facility Name (if not institution, give street ity of Deat W If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland . Age (In vrs. last birthday If Under 1 Year 8. Date of Birth **Funeral** 1 M 2X F Dec. 30, 1940 Hours **Director** 220-36-2374 70 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland Examiner must be notified at 10d. Inside City Limits Director Randallstown Md. Balto. 1 Yes 2 No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a USA 21133 8337 Liberty Road within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. ō δ 1 Never Married 2 Married 2 XNO Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: 'natural", Specify. Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (9-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Department of Health and Menta Important: If item 27 is marked any injury or other transcores 2 Laura A. McGuire Thomas D. Lyell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 Rugby Avenue Balto. Md. 21225 Nephew Mike Stoffel 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5-26-2011 Glen Burnie, Md. Atlantic Crematory 21. Signat re of Funera Service Licensee 22. Name and Address of Facility ^{2. Name and Address of Facility} Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 21236 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ardiovasculara Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death3 <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available has autopsy prior to completion of cause of death? anemia 1 🗌 Yes Yes or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Inpatient 2 ER/Outpatient DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d, Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year, lan State 26 2011 Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 011 May 21, Christina Denise LeCompte 12:10a M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Halethorpe Baltimore 5004 Hazel Avenue Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Oct. 10, 9. Birthplace (State or Foreign **Funeral** Days Months Year) 1 □ M 2 🛛 F Hours 51 Maryland 218-74-8116 $^{'}1959$ **Director** Usual Residence of Decedent 23a or 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Halethorpe MD Baltimore 10f, Zip Code 10e, Street and Number 10g. Citizen of What Country? Completed by Funeral United States 21227 5004 Hazel Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. Armed Forces 1 Never Married 2 XMarried 1 Yes 2**X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: 3 Divorced 4 Divorced Year or Dates 16a Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Food Service Waitress 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) June Christine Scott Linden H. Bowman, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5004 Hazel Ave., Halethorpe, MD 21227 19a. Informant's Name/Relationship (Type, Print) Michael LeCompte - Husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ☐ Burial 2 Noternation 3 ☐ Removal from State 4 Donation 5 Other (Speciny) May 26,2011 Atlantic Crematory Glen Burnie, MD 22 Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final CHRONIC Enysician/ OBSTRUCTIVE PULMONARY disease or condition resulting in death) 5+YRS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of: Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. the attending physician and thed for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day g Unknown P.O. been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an prior to death? has e 2 s autopsy performed? certificate I 1 Yes 2 No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) director, examiner?

1 Yes 2 No Other: 4 - Nursing Home 5 - Residence 6 - Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔀 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide within 24 hours after de To the Funeral Directo completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the only one 29d. Date signed (Month, Day, Year) MEDICAL DOCTOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M-D MALIK 724 MAIDEN CHOICE LANE CATONIVILLE MD 2122/8 KABINA 31. Date filed (Month, Day, Year) 2. Registrar's Signature park State MAY 2 6 2011 Registrar

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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death Month Physician/ 12:25 PM Betty League May 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Tate Hospice House Anne Arundel Linthicum Social Security Number If Under 24 Hrs. If Under 1 Year 8 Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours Min (Month, Day, Year) May 7, 1941 1 🗆 M 2 🗶 F 70 **Director** Maryland 214-38-4088 Usual Residence of Decedent or 28a-f show ind Mental Hygiene. marked other than "natural", or items 23a or 28a-f shou matic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 XNo Maryland Pasadena Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21122 216 Kenwood Road filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 X No 3 ☐ Widowed 4 ☐ Divorced SpecifyWhite Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Distilary Secretary 12 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be file rtment of Health and Mental I rtant: If item 27 is marked o Elizabeth Sara Hoback unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Kirby Friend 214 Carvel Road Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town. State Date cemetery, crematory or other place 5 1 Burial 2 Cremation 3 Removal from State May 2011 Department of Important: If any injury or Baltimore, MD 4 Donation 5 Other (Specify) Metro Crematory, Inc. 22. Name and Address of Facility
Stallings Funeral Home, P.A. 21. Signature of Funeral Service Licenses 3111 Mountain Road Pasadena Maryland 21122201 23a. Parl 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Chrome obstructive Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Osteopovosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last **burial** attending physician for use as the buria Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Dav Pregnant at time of death 2 □ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Anxiety disorder 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed Depression 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe page 1 🗌 Yes 2 🗆 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 X No 1 Yes မြ 1 Inpatient 2 I ER/Outpatient 3 I DOA nospice 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) After this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No neral Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Funeral E Medical 29a. Certifier 🛮 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of certifier 29c. License number

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DHMH 17 Rev 7/2009

State Registrar HII Madison Pank

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Year)

31. Date filed (Month, Day,

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May

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 10:39 PM John F. Ledbetter Jr. 2011 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Itimare N/A Numb 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday Funeral 1 X M 2 □ F Months Hours Min 212-72-1024 089930 Y 1939 N. Carolina 71 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a State 10c. City, Town or Location Director 1 XYes 2 No N/A MD Baltimore = 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 519 Mt. Holly St. 21229 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black White etc. ģ 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 11th Grade College (1-4 or 5+) Factory Worker Sheet Metal Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 John F. Ledbetter Shirley Mae Rozier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Douglas(sister) 4020 Walrad St., Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) on-site Crematory 05/24/11 Baltimore, MD ²Josephorn of Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 21. Signature of Euneral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between ONGESTIVE Immediate Cause (Final HEART FAILURE Onset and Death Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner il any leading to in reclicause. Enter Underlying Due to for as a consequence of or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and -tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy yes 2 No 1 🗌 Yes 2 🗌 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After t
completed filled in by the funera 1 Natural 5 Pending work 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 1)005/865 AGNES 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CURTIS 31. Date filed (Month, Day, Year) - - -State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2011 May 23. 5:30 Рм Delfina Lamboy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford 509 Cider Press Ct. Apt. Joppa 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗷 F Months 12/24/15 Puerto Rico **Director** 95 106-24-7541 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Harford Joppa 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 509 Cider Press Court Apt. M 21085 within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give δ Maryland 21215-0036 1 Yes 2 No Specify. 3 ⋈ Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 2 should be filed within 72 l h and Mental Hygiene. 7 is marked other than "n Elementary/Seconday (0-12) 12 College (1-4 or 5+) Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic <u>Cornelio Quirindongo</u> Rosa Torres 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joppa, Md. 21085 Robert Vega / Son-in-Law 509 Cider Press Court Apt. M Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 M Burial 2 Cremation 3 Removal from State Municipio de Ponce Ponce, Puerto Rico 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Due to (or as a consequence f): Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy Live Birth 2 Fetal death 3 in the past 12 months? Day Year Month Pregnant at time of death 5 Other (specify) signed by the a 1 Yes 2 Unknown 2 No P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? To the Hospital or Attending Physician: The law performed? 1 Yes 2 No certificate Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 27. Manner of Death 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 🗌 Yes 2 🗆 No Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D35288 24 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 6 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nancy Louise Mandley AM 5330 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Himore 7. Age (In yrs. last birthday) Year If Under 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 1 F Min. Jan. 31, 1948 216-52-7543 Months Days Hours 63 Baltimore, MD Director Usual Residence of Decedent shov 10a. State 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2816 Christopher Avenue 21214 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: White Specify: 3X Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working pernit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than 'any rijury or other traumatic event, the Meany rijury or other traumatic event, the Me life. DO NOT use retired) At Home Elementary/Seconday (0-12) College (1-4 or 5+) Housewife 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Albert Cronin, Helen Chase Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Mandley- Son 18 Stoneway Place, Nottingham, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place Evans: Puneral Chapel 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Forest Hill, MD 2011 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee 22 Name and Address of Facility Evans Funeral Chapel & Cremation Services Parkville, MD 21234 Harford Road, 23a. Pan'l. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death stlock, or heart failure. List only one cause on each line In mediate Cause (Final disease or condition resulting in death) Physician/ arrhythmi Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Il any, I act is a cause. Enter Underlying Examine Dise to for as a nonsequence off ng physician and as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 JE FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death page 2 should be detached Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 2 1 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, it 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 1 No မှ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide the Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Kathlian John D062689 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) **MAY 2 6 2011** State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item# 18,20b, per fh, g916 6-22-11 sm State of Maryland / Department of Health and Mental Hygiene | For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Montgomeru Monroe 0547 AM 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Baltimore County of Death Baltimore Maraland yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 **■** M 2 □ F (Month, Day, Min MISSOU Director Decedent s 23a or 20a. nust be notified at or 28a-f show 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a 10c. City, Town or Location 10d. Inside City Limits by Funeral Director 1 Yes 2 □ No 10f. Zip Code 10g, Citizen of What Country? and Mental Hygiene. is marked other than "natural", or items 23s aumatic event, the Medical Examiner must I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working the DO NOT use retired) Decedent's Education 16b. Kind of Business Industry pecify only highest grade completed) aday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) ည M. Griffin Mailing Address iral Route Number, City or Town permit, Page 1 and 2 Department of Heath Important: If item 27 any injury or other tr once. thod of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21195 21. Signature of Funeral Service License Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Due to (or s a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month 5 Other (specify) Day 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔭 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 1 Yes 2 No 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No ည 1 ☐ Inpatient 2 ➤ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at XNatura! 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be . Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 209772 May 24 2011 Unixersity of maryland medicale center 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD St. Yaziol almalkin 22 5 Greene MAY 26 2011 State Registrar

DHMH 17 Rev 1/2001

Physician)/Medical Examiner

Physician /Medical

Examiner

10a. State

jo

Funeral

Director

permit. Pages 1 and 2 should be fled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certification: To Be Completed by Physician/Medical Examin
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Director	MD N	A B	altimore		Thes 2 Into						
Ě	10e. Street and Number	01	10f. Zip-Code		0g. Citizen of What Country?						
	1321 Elmtr	ree St	21226	USA	<i>I</i> +						
	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican,	n? (Specify Yes or No- Puerto Rican, etc.)	 Race - American India Black, White, etc. 	ın,					
	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give	1 ☐ Yes 2 ☑No Specify:		Specify: Blac	K					
	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E	Year or Dates:	a. Decedent's Usual Occupation	16	b. Kind of Business/Industry						
	(Specify only highest gra	ade completed)	(Give kind of work done during most of life. DO NOT use retired)	of working							
1	Elementary/Secondary (0-12)	College (1-4 or 5+)	ITA BUS OPE	rator	Iransport	KOTES					
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2	Walter Mu	ray Si	Ca	therine	Murray	<u> </u>					
	19a. Informant's Name/Relationship (Type. Print) 19	b. Mailing Address (Street and Number		1 1						
	Christina Tara	pley-Murray 1	321 Elmtree	<u> </u>	Himore, MD	21224					
	20a. Method of Disposition 1 Purial 2 Cremation 3		of Disposition (Name of tery, crematory or other place)	Date 20	c. Location - City or Town, Sta	ite					
	4 Donation 5 Other (Special	(y) Har	mony 5	1/27/2011 14	yattsville, 1	<u>ab</u>					
	21. Signature of Furieral Service Licer	isee.	22. Name and Address of Facility	Howell	Funeral	How					
	Mean of	- House	41.4600 hiberry	Heights 1	the Balto	ximate					
	23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Done cause on each line.	o not enter the mode of dying, such 🚨	ardiac or respiratory arres		al Between and Death					
	Immediate Cause (Final disease or condition	a Acute my	elocytic leuk	emia							
	resulting in death)	Due to (or as a consequence	e of):		1						
	Sequentially list conditions,	b	on off:								
	if any, leading to immediate Due to (or as a consequence of):										
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200	•	d									
M M	IF FEMALE:	23c. If yes, outcome of pregnancy			23d. Date of delivery						
by Physician/Medical	23b. Was decedent pregnant in the past 12 months?	 1 ☐ Live birth 2 ☐ Fetal dead 4 ☐ Pregnant at time of death 			Month Day	Year					
n/SI	1 Yes 2 No 9 Unknown	9 Unknown									
<u>></u>	Part II. Other significant conditions	contributing to death but not resulting	g in the underlying cause given in Part I		acco use contribute to the cau						
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Completed				24a. Was an autopsy	prior to completion of cause of						
Ĕ				performe	ed? death? No 1 \(\text{Yes} \) 2 \(\text{No} \) No						
	25. Was case referred to medical		26. Place	of Death (Check only one)	Death (Check only one)						
ם ס	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/	Outpatient 3 DOA Other: 4 Nur	sing Home 5 - Residen							
•	27. Manner of Death		b. Time of 28c. Injury at Work?	28d. Describe hov	v injury occurred						
2	1 Natural 5 Pending 2 Accident investigation	on	M 1 Tes 2 T								
<u>د</u>	3 Suicide 6 Could not determined	be 28e. Place of injury - At home building, etc. (Specify)	, farm, street, factory, office	28f. Location (Str. Cify or Town,	eet and Number or Rural Rou State)	te Number,					
5											
200	29a. Certifier 1 CertifyIng P	aminer: On the basis of examination	dge, death occurred at the time, date an and/or investigation, in my opinion, dea	d place, and due to the ca th occurred at the time, da	use(s) and manner as stated. Ite and place, and due to the	cause(s)					
Medical Celulication.	one)	and manner stated.	29c. License number		d. Date signed (Month, Day, Yo						
	29b. Signature and title of certifier	101	PES- 00		1011 27	1100					
	16144 C	yu, mo		7	ring of ot	LIUX					
	30. Name and address of person wh		3a) (Type, Print)	600 North Wolf	e St, Baltimore, I	MD. 212					
	31. Date filed (Month, Day, Year)	ARWAL 32. Registrar's Signatus		000 110/11/1 110/1	- Jt, Daniii.o.o, 1	,					
e		32. Registrar' Signature	New								
1	MAY 26 2011	1									

DHMH 17 Rev 1/2001

Registrar

MAY 26 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death HELEN MARTIN Physician/ 6.40 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SANDTOWN FUTURE CARE BATIMERE N/A If Under 1 Year | If Under 24 Hrs. | Months | Davs | Hours | Min. | 5. Social Security Number 2 1 7 - 20 - 2485 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛮 F Dec31, 1915 95 Director Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State MD 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director N/A Baltimore 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1104 Shellbanks Rd. 21225 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify:Black 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore Ci_{ty} Elementary/Seconday (0-12) College (1-4 or 5+) ParaProfessional Public Schools 2Yrs. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: if item 27 is marked any injuy or other traumatic evennee. Arthur Cloud Jessie Collins 19a. Informant's Name/Relationship (Type, Print)
Beverly Prater/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3706 Eldorado Ave Balto., MD 21207 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Cem Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 5/31/11 Lansdowne, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Beverly D. Cromartie F/S 2700 Edmondson Ave. Balto., MD 21223 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death DEMENTIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): ARDIOM TOPATHY that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year 1 Yes 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? After this certificate 1 ☐ Yes 2 ☐ No 2 No Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) 2 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No 1/ Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ATTENDING 00057948 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21229 AVE, BALTIMORE MO YOUNGMY MO WILKENS JANE 3455 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 26 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ dene 7400 Medical Facility Name (if not institution, give street and number **Examiner** Social Security Number Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 M 2 X (Month, Day, Year July18, 1 Min. 241-54-2716 75 **Director** Yrs 935 NĆ Usual Residence of Decedent 10a. State MD 10b. County with the Maryland 10c. City, Town or Location notified at 10d. Inside City Limits Director N/A Baltimore 28a-f 1 X Yes 2 □ No 10f. Zip Code 21 223 10e. Street and Number ò 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 1818 W. Lafayette Avenue USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 21215-0036 Yes 2 🗶 No If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: Black "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) 12th College (1-4 or 5+) N A permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any Injury or other traumatic event, the N Industry Laborer Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ David Morehead Blanche Cates 19a. Informant's Name/Relationship (Type, Print)
Carlton Morehead/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1818 W. Lafayette Ave. Balto., MD 21223 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Final Journey 6/3/11 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of FacilBeverly 2700 Edmondson Ave. D. Cromartie F/S Balto., MD 21223 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ung disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examir burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): nding physician ause as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atter 3 Cther (specify) in the past 12 months?

1 Yes 2 No
9 Unknown jo Day Year Pregnant at time of death signed by the a d be detached for the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed plnous peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy the Funeral Director. After this certificate 2 No Yes 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) retion examiner? 1 🗌 Yes 2 (Z/No ပ 1 🗌 Inpatient 2 🗌 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury death. 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death oc only one) curred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat and title of o 29d. Date signed (Month, Day, Year) ess of person who completed cause Name and address of death (Item 23a) (Type, Print) 97 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 26 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TIEM#5perFH, G918,8/2/2011, WS
State of Maryland / Department of Health and Mental Hygiene? State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May Physician/ 2011 McAneny 9:45 A M Lucy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring 2312 E. Gate Dr. 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year
July 9, 1 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday **5**50°38™9636 **Funeral** 1 □ M 2 🛣 F Days Hours 85 Kansas Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits the Maryland 10c. City. Town or Location notified at Director 1 Yes 2 No Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ ms 23a or must be r Funeral 20906 2312 E. Gate Dr. United States items 2 Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2XXNo Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2XXNo Specify: If Yes Give Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Southern Illinois Unv College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Higher Education College Administrator Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ည Buess Walter Bruce Garnett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20906 2312 E. Gate Dr., Silver Spring, MD Laurence R. McAneny II / Sone Department of Health Important: If item 27 any injury or other th once, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State Beltsville, MD Uniformed Sers. Univ. 05/24/2011 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD M00382 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 24 HOURS Immediate Cause (Final Physician/ HEART FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner CARDIAC ARRHYTHMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 in the past 12 months?
1 Yes 2 X No Por Month Day Year 5 Other (specify) Pregnant at time of death bed f the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2XXNo 3 Probably 4 Unknown should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? Yes 2 X No death? 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) director. Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 2 X No ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this funeral . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No iniury X Natural 5 Pending 24 hours after death. Funeral Director: A Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1XXCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only and title of certifier 2 30. Name and address of person completed cause of death (Item 23a) (Type, Print) 20902 SILVER SPRING, MD PENNY L. M.D. 10301 GEORGIA AVE, BI\$K 6 32. Registrar's Signature State arke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene-State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ : 15 AM Medical not institution, give **Examiner** street and number, 4b. City, Town, or Location 4c. County of Death 14anda Mort 8 Date of Birth If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Months **Director** Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits be filed within 72 hours after death with the Maryland Town or Location Director 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1209 by Funeral USA Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14 Bace - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. , L Yes 2. If Yes, Give Year 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Be Eather's Name (First. Mother's Name (First, Middle, Majden Surname) Middle, Last ೭ nae Informant's Name/Relationship (Type Print permit. Page 1 and 2 sh Department of Health ar Important; If Item 27 is any injury or other tra Balto. MD sbano Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State gemetery, crematory or other pla Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ss Balto mo 21225 ter the disease, or complications that caused heart failure. List only one cause in each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. P.O. Box 68760 res, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Other (specify) Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No has this certificate 2 No 1 Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 2 X No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 28b. Time of Certificate: 28d. Describe how injury occurred 24 hours after death. Funeral Director; After Natural iniury 5 Pending 2 No Investigation Accident Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 0 em 23a) (Type, Print) Name and address 32. Registrar's Si

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month MAY 2011 MECKLER 9:14 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE 538 CHURCH ROAD REISTERSTOWN 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

D Δ 8. Date of Birth **Funeral** 1 🛛 M 2 🗆 F Min Marth 18/1926 Director 206-26-9027 84 PA Usual Residence of Decedent 23a or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD BALTIMORE REISTERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 538 CHURCH ROAD USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 X Yes 2 ☐ No Black, White, etc. þ 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates WHITE Specify Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PUBLIC RELATIONS ISRAEL BONDS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MECKLER SARA MACHLIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY MECKLER/WIFE 538 CHURCH ROAD, REISTERSTOWN, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/25/2011 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. rate 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death h sician/ Medical resulting in death) Examiner Sequentially list conditions Examiner cause. Enter Underlying the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) Month Year 9 Unknown been signed by 1 should be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed' 2 🗌 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide 1 Tes 2 🗌 No Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 [3 [Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 30. Name and address of pe ho completed cause of death (Item 23a) (Type, Print) State Registrar

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29b. Signature and title of certifier PHUSTUAN 2ND DEDECTOR 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) Town. I And Hose SQI - N - GWAW ST SWIE 30'B PAUTMONE WWD 2120/	t P 2	e Hospita 24 hours e Funeral	ledical	(Check 2 L Medical	Examiner: On the basis	s of examination	n and/or invest	igation, in m	v opinio	n. death o	ccurred at	the time, date a	and place	, and due	to the ca	use(s) and manner stated.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death COMMONIT ヘクロ UVIN69 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Yea 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min Maryland 0 990 69 1935 219-28-3361 Director 75 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No N/A MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 825 Kevin Rd. 21229 U.S.A 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married þ 1X Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+years Asbestos Inspector Air Force 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert Greenway Pearl Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Johnson(cousin) 825 Kevin Rd., Baltimore 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 06/02/11 Owings Mills, 21. Signature of Funeral Service License ²Joseph H. Brown Jr. 2140 N. Fulton Ave., Funeral Home PA Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending 2 🗌 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. of death (Item 23a) (Type, Print) OCH RNEN BUD 31. Date filed (Month, Day, Year) State 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2<u>011</u> Month 7:55P Matthew G. Pinkas Sr May 21 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House <u>Westminster</u> Carroll Social Security Number **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Country)
MD Hours (Month, Day, Year) 10-27-1923 217-18-8018 87 **Director** Usual Residence of Decedent 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified MD Carroll .28a-f Westminster 1 Yes 2X No 10e, Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral with 1 4015 Arters Mill Rd. 21158 USA items Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Fant. If item 27 is marked other than "natural", or items lury or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian rmed Forces?

Yes 2 No Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify. Completed 3 Widowed 4 Divorced Specify:white Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Farming Dairy Farmer 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Matthew J. Pinkas Frances Havlik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne Pinkas-wife 4015 Arters Mill Rd., Westminster, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Department of H Important: If ite any injury or otl Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 5-25-11 Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Mem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home 1 homas 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARDUMUPATH Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Hospital or Attending Physician: The law requires that the death in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown Yes 2 No detached 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Tunknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 24 hours after death.

Funeral Director: After this certificate 2 No 1 Yes 1 Yes funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? INVATIC 2 🗗 No Other: 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death MOSPICE 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No filled in by the Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signa e and title of certifier 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Typ THE WESTMINSTER, MI) 31. Date filed (Month, Day, State 2 6 2011 Registrar

ORIGINAL

DHMH 17 Rev 7/2009

DHMH 17 Rev 1/2001

Registrar

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AMEND ITEM#20b, perFH, G916, 6/7/2011, WS
State of Maryland / Department of Health and Mental Hygiene 2011 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month Day 6:45 PM Martha Lene Peters 05 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/ABaltimore Union Memorial Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Days Hours Min. 0674271938 Maryland **Director** 216-34-2555 72 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No N/A MD Baltimore 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21217 1614 Balmor Ct. U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self Domestic 10th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ William Jackson Hannah Barnett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1614 Balmor Ct., Baltimore, MD 21217 Tonya Peters(daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 06/01/2011 cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State on-site Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) $\frac{105}{26}$ 21. Signature of Funeral Service Licenses Joseph Ades of Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ ongestive disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner week Elevation Bequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the attending phone of the transfer of the tra IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 ☑ No Other: ျ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 3 Contifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and tit of certifier 29d. Date signed (Month. Day, Year) AT-2438946 05 21, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Omar Gowayed M.D. Union memorial Hospital 201 E. University Pkwy Baltimere, MD 21218 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician DOROTHY MARY ROSE 10:10P 24 2011 MAY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner RIVERVIEW NURSING HOME **ESSEX** BALTIMORE yrs. last birthday, 8. Date of Birth (Month, Day, Year) 7 – 23 – 1921 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 9. Birthplace (State or Foreign **Funeral** Days Min. Hours Months 1 □ M 2**X** F 220-01-4455 MARYLAND Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show If e Modical Examiner must be notified at MD BALTIMORE RASPEBURG 1 ☐ Yes 2 XNo Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5839 N. HAZELWOOD AVENUE 21206 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐Yes XIXNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) LINE WORKER 4 ROSES DISTILLERY is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 'nent of Health and Mental **HENRY** WOLF MARTE BERNHARDT ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) WAYNE W ROSE/SON permit. Pages 1 and 2 s
Department of Health au
Important: If Item 27 is
any Injury or other trau
once. 5839 N. HAZELWOOD AVE BALTIMORE, MD 21206 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State GARDENS OF FAITH 5-27-11 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Fun 1211 CHESACO AVE ROSEDALE, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** DEMENTIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed sician and burial-tran Due to (or as a consequence of) Box 68760, physician s the burial Physician/Medical attending pl yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No P.O. been signed by the should be detached 9 Unknown 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy certificate 1 □Yes 2 ☑No Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 5 Pending Injury n 24 hours after death.

ne Funeral Director; A
pletely filled in by the fi death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the Hosp within 24 hor To the Fune completely fi eck only and manner stated signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. MAY 26,2011 D0060560 30. Name and address of person who o

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene U Certificate of Death Reg. No. L. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Geraldine 05 2011 8:00A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3828 Ferndale Ave Baltimore Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Months Hours (Month. Day, Year) Director 218-30-528 VΑ Usual Residence of Deceden 28a-f show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No NA Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3828 Ferndale 21207 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. 1x Never Married 2 Married þ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: 3 Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7 and Mental Hygiene. 7 is marked other than Greater Baltimore Elementary/Seconday (0-12) College (1-4 or 5+) <u>Dietician</u> 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ injury or other traumatic McKinley Redd Ella Woodson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau <u> Ethel Mise-Sister</u> Baltimore 5707 Key Ave. Md. 21215 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Woodlawn 5/21/2011 Woodlawn, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Av 21. Sign sture Ave, Baltimore. 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final CANCER Physician/ disease or condition 2MWTH> Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Liner Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Day signed by the a d be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 Se No 3 ☐ Probably 4 ☐ Unknown 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performe page 2 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of e Hospital or Attending Pi 124 hours after death. e Funeral Director: After the pleted filled in by the funera 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending work?
1 \sum Yes 2 \sum No 2 Accident
3 Suicide Investigation 6 Could not be To the Hospital or Atterwithin 24 hours after de To the Funeral Directo completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1600 OSLER 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 6 2011 2 Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month ablitton am 10 Medical 4a. Facility Name (if not inctitution, give street and number) 4b, City, Town, or Location of Death Examiner 4c. County of Death Richev Hospice ${ t Baltimore}$ Joseph If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 1**火** M 2 □ F Days 06 13 49 Months Hours Min. Director 215-52-3944 61 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director NA Baltimore 1 X Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 616 Homestead Street 21218 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specialack Completed 3 Widowed 4 Divorced Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 2th grade Cook Private it. Page 1 and 2 should be filed with thrent of Health and Mental Hygien rtant: If item 27 is marked other 1 njury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ralph Robinson Sr. Wilnette Dandridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 910 permit. Page 1 and Department of Heali Important: If item 2 any injury or other t Wilnette D. Robinson-Mothek 2500 West Belvedere Ave Apt Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) On-Site 5/24/2011 Baltimore, Md Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition. Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) sician and burial-trans Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown be detached for Month 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe this certificate 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred after death. Director: After 1 injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide
Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital within 24 hours a To the Funeral D Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H0064267 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State Registrar DHMH 17 Rev 7/2009

20/

Son

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-03663 State of Maryland / Department of Health and Mental Hygiene Peter Timothy Renghofer 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3, Time of Death Physician/ Month Day May 15, 2011 1631 hrs Medical Examine Renghofer Timothy Peter 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Lutherville Timonium 1014 Jemirson Road Jamieson Road If Under 1 Year If Under 24Hrs. 8, Date of Birth (MM/DD/YYYY) 9, Birthplace (State or 6 Sex 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Director 60 12 Country) Maryland 1 X M 2 F 1950 Nov. 218-54-2279 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 X No Maryland Baltimore Lutherville Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiens and an art. If item 27 is marked other than "natural", or items 23a or 28a-f sho enter traumatic event, the Medical Examiner must be notified at once or other traumatic event, the Medical Examiner must be notified at once. 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Ö 1014 Jamieson Road 21093 uneral 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No Yes White 3 Widowed 4 Divorced Yes, Give Year 1 Yes 2 X No specify: Specify: ۵ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry eted Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Compl 4 years Bar/Restaurant Bar Manager 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Michael Renghofer Ann Margaret Schwartz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Elizabeth Smith (Per. Rep. 6 Buchanan Road Baltimore, Maryland 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 5-19-11 Baltimore, Maryland Department Green Mount Crematory 4 Donation 5 Other Specify. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, 6500 York Road Baltimore, Mary 21. Signature of Funeral Service Licensee Inc. 21212 Baltimore, Maryland Approximate Interval art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death Immediate Cause (Final disease a Hypertensive Atherosclerotic cardiovascular disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and ician/Medical Mended 4a per me g915 5-20-11 vt 23a,pt.II,27,per me,g915 5-26-11 sm **UNPENDED** attending physician or use as the burial Records, P.O. Box 68760. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Year Live birth Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the 1 be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 8 1 Yes 2 No 3 Probably 4 Unknown Diabetes, chronic alcohol abuse Completed has been s 2 should l 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed? death? page ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Division of Vital examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene 1 Yes 2 No 28a. Date of Injury (Month, Day,Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 28b. Time of Injury 1 X Natural 1 Yes 2 No 5 Pending Director: after death. 2 Accident led in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be 4 Homicide Vithin 24 hor To the Func completely fi 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s). 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month. Day. Year) 29b. Signature and title of certifie 29c. License number 10 O.C.M.E. May 16, 2011

Registrar

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

30. Name and address of person who completed cause of death (Item 23a)

OCME

Victor Weedn MD JD

31. Date filed (Month, Day, Year)

MAY 2 0 2011

LÉ

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Annie Russell Ricks 3:58 p May 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Brighton Gardens at Friendship Chevy Chase Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😾 F Months Days Hours Min. (Month, Day, Yea ov 26 1 **Director** 012-22-2304 Massachusetts Nov Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits at Director notified MD Montgomery Chevy Chase 1 Yes 2 No 10f. Zip Code 9 10e. Street and Number 10g. Citizen of What Country? pe I ral", or items 23a Examiner must b Funeral 5555 Friendship Blvd. 20815 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedon __ Armed Forces? 1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White 3 🕅 Widowed 4 🗆 Divorced "natural" Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ige 1 and 2 should be filed within of Health and Mental Hygiene t If item 27 is marked other th Political Activist Politics 4 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Richard Manning Russell Helen Munson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Sumers (daughter) 93 Montrose Station Rd. Montrose, NY 10548 May Date 26, 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State Beltsville, MD 2011 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 22. Name and Address of Facility Rapp Funeral & Cremation Service 21 M00982 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ₽h, sician/ Months disease or condition resulting in death) Inanition Medical Due to (or as a consequence of): Examiner Dementia Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examin requires that the death certificate be executed and -trar that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical Box 68760 use as 1 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month ō Day Year 5 Other (specify) Pregnant at time of death 2 X No the 9 Unknown 9 Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Julknown Records, Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has page 2 autopsy performed' death? Physician: The 1 ☐ Yes 2 ☐ No 1 Yes 2 XNo **Division of Vital** 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After Hospital or Attending iniury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number City or Town, State) pleted filled in by 4 Homicide determined Medical 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature.a 29d. Date signed (Month, Day, Year) D39456 May 24, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5530 Wisconsin Ave. Suite 1400, Chevy Chase, MD 20815 Lila T. McConnell, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death Reg. 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Physician/ Month nau 3017 Medical 4a. Facility Name (if not institution, give stre 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Baltimore Bon Secours Hospital Social Security Number 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Months 12/03/1943 67 UNK SC Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natura" any injury or other traumatic events. 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21217 1000 North Gilmore Street USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hospital 12 <u>Custodian</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Annie Ponds Alvester Rodgers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4141 Mountwood Rd Baltimore MD Lisa Cole Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State At I and I compared of the place) 05/21/11 Glen Burnie MD 4 Donation 5 Other (Specify) 22. Name and Address of FacilitySimplicity Crem & Fun Serv Funeral Service License Thomes ThomasAllenP.A. 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events as consequence of): Exami attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the a d be detached f Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? certificate 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medical Be eral Director: After this certific filled in by the funeral director, 26. Place of Death (Check only one) Hospital Other: 2 X No 1 Yes 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Tes 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined within 24 hours a Medical Lectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 55

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 24, **Physician** Everett Clinton Robinett 0113 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford 8. Date of Birth (Month, Day, Year) 06/27/1924 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 1 X M 2 □ F Months Days Hours Min. 86 Director 229-16-2324 Virgina Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examinar must be mortified at Directo Maryland Harford Yes 2 □ No Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1313 Currier Street 21078 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? ★XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ★★Yes 2☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ white 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 service man heating/air conditioning marked other 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) should be f and Mental ပ Claud Robinett Important: If Item 27 is mark any injury or other traumatic Stella Mae Bailey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vera S. Nichols (daughter) Currier St., Havre de Grace, MD 21028 Baltimore, . Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Gardens 5/28/11 Aberdeen, Maryland 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 21. Signature of Funeral Service Licensee Aberdeen, Maryland 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** EXACEPBATION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ULMONARY Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be execute resulting in death) Last physician a the burial-1 Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy certificate 2 No Division of Vital 1 ☐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hor To the Fune completely fi Medical (Check only one) and manner stated

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State Registrar KHALID

31. Date filed (Month, Day, Year,

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 501

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Martha Delia Rios 21 2011 8:10 P M May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Potomac Valley Nursing Center Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) 1 □ M 2 🗓 F Yrs. Director 579-64-5473 76 1935 9. Argentina Jan. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examinar aust by notified at MD Director Montgomery Rockville 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1235 Potomac Blvd. 20850 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1⊠Yes 2□No *Specify:* Spanish If Yes, Give Year or Dates: ρ Specify: White 3 Widowed 4 Divorced Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Non-profit Elementary/Secondary (0-12) College (1-4or 5+) Accountant Organization 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Manuel Joaquin Rios Maria Antonia Fernandez ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rudolfo Ricagno / Friend 4445 Indigo Lane, Harwood, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) Science Care 05/25/2011 Phoenix, AZ 21. Signature of Funeral Service Licensee M00382 RapportdAeral Falld Cremation Services Styles Lohman 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-transi Due to (or as a consequence of) Box 68760, The law requires that the death certificate be Physician/Medical attending pl for use as tl IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Month Year signed by the a 5 Other (specify) P.O. 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Nnknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1 ☐ Yes 2 🗖 No or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death
1 Natural
2 Accident Certification: 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the f 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 170021214

State Registrar

MAY 26

7133 MILLRUN DR., DERWOOD, MD 32. R gistrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2011

AHMED HESHMAT, M.D.

31. Date filed (Month, Day, Year)

20855

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 2011 16 14 Stanley aywood Medical County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 15/2 1timon Landall) town Northwest Hospital 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral V** M 2 □ F Month Day, Months Hours Min. Yrs. **Director** 229-48-9205 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 🔼 Yes 2 🗌 No Baltimore NA MD 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Funera U.S.A. 21244 Place #101 2400 Battersea 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Force Yes 2 X No 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black If Yes, Give 3 Widowed 4 Divorced ted Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education Complet (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) of Public Works Dept. of Publi Baltimore City Elementary/Seconday (0-12) College (1-4 or 5+) na Driver 12th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Lest) မှ Carrie Stanley Havwood Stanley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21244 19a. Informant's Name/Relationship (Type, Print) #101, Baltimore, Place, 2400 Battersea Stanely-Wife Avis 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/2/2011 Woodlawn, Md Memorial Park 22. Name and Address of Facility March F/H West 4300 Wabash Av Signature of Funeral Service Licensee Baltimore, Md Ave 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ Month Day Year in the past 12 months?

1 Yes 2 No
9 Unknown signed by the atte Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Preumonic-Division of Vital Records, Completed Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performe death? Yes 2 N 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Certificate: To Be examiner? Hospital: Other: 1 🗌 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral I 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Manner of Death 28c. Injury at 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day. Year) 29b. Signature and title of certifier 201 10062650 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) randalistaun MD 7/137 5401010 cout roa State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #29d Per Phy G915 5/26/2011 JH State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** STASEK 07: 40 AM RHONDA MAY 24 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL HARBOR BALTIMORE If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Pay, Year) 1/25/1957 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 □ M 2XXF Months 216-70-3523 54 MD Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 102 Gordon Lane USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Tyes 2 X
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) L.P. Nurse Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pearl Ganoe Carroll Leatherman 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Joseph A Stasek / Husband 102 Gordon Lane Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place. 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ebenezer UMC Cemetery 5/28/2011 Romney, West Virginia 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 M01220 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE RESPIRATORY disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse juence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RENAL FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Gastro intestina 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2. ☑ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifie 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number Pate signed (Month Pay, Year) 29b. Signature and title of certifier

Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Division of Vital Records, P.O. Box 68760 attending p been signed by the should be detached certificate has birector, page 2 s director After this within 24 hours after death.

To the Funeral Director: A
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Department of Health a Important: If item 27 is any injury or other tra once.

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State Registra

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Baltimore.

3001 South Hanover Street

MD

Resident, PGY-1

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Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 'ک3' Physician/ 2011 Alice M. Smith May 21 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Catonsville Baltimore Frederick Villa Nursing Home 8. Date of Birth Aug. 17, 1916 9. Birthplace (State or Foreign Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months Hours Min. 1 □ M 2 🗓 F 94 Maryland 220-09-3679 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🗆 Yes 🚈 No Halethorpe Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō be ms 23a must be Funeral United States 21227 1244 Francis Avenue Page 1 and 2 should be filed within 72 hours after death verent of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes Give White Completed 3 XWidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Agnes Kenny George T. Murray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
r 1244 Francis Avenue, Halethorpe, MD 21227 19a. Informant's Name/Relationship (Type, Print) Colleen Smith-Orendorff-daughter permit. Page 1 and 2 Department of Health Important; If item 2 any injury or other 1 once. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State Druid Ridge Cemetery | 5-25-2011 Baltimore, MD Donation 5 (ther (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. Puneral Service License 1328 Sulphur Spring Rd., Arbutus, MD 21227 Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each line men ora Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-transi resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation neral Director; A 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a To the Funeral C completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier iden Choir long Hold Wills 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Yes State Registrar

DHMH 17 Rev 7/2009

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ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ Year 6:17 A_M Franklin Joseph Schaefer 2011 Medical May 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Baltimore **Examiner** Stella Maris 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours Min. 1 X M 2 🗆 F 99 216-05-9877 Yrs **Director** 18. 1912 March Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location items 23a or 28a-f sho her must be notified at 10d. Inside City Limits Director Baltimore Halethorpe MD 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21227 USA 4613 Maple Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian ortant: If item 27 Is marked other than "natural", or iter injury or other traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No Rlack. White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) pernit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic. Elementary/Seconday (0-12) Industrial Tool Supply Inside Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Anthony Schwartzenburg Christopher George Schaefer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4613 Maple Avenue Halethorpe Maryland 21227 Donald E. Schaefer Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 🗴 Burial 2 🗆 Cremation 3 🗆 Removal from State Donation 5 Other (Specify) eadowridge Mem Park May.27,2011 Elkridge Maryland 22. Name and Address of Facility Ambrose Funeral Home Inc. 1328 Sulphur Spring Road Arbutus Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition SEPSIS Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of) Examir Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ P.O. Box in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 X No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural work? 1 \(\sum \) Yes 5 Pending thin 24 hours after death.

the Funeral Director: Aformpleted filled in by the fu 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 23/201 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add 2300 DULANEY VALLEY RD. JACKIE JONES. CRNP TIMONIUM, MD 21093 State MAY 2 6 2011 Registrar

DHMH 17 Rev 7/2009

a.m.

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SCHAEFER

State of Maryland / Department of Health and Mental Hygiene 2 for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death May Physician/ 2³3 20T1 7:15 P M Shapiro Susanna Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 9 Montgomery Rockville Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 0 Min. Feb. 25, 1925 Months Hours ^{Country)} Ukraine 86 Director 218-25-0103 2011 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10c. City, Town or Location aţ Director should be filed within 72 hours after death with the Marylan and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-fs sammatic event, the Medical Examiner must be notified aumatic event, the Medical Examiner must be notified. 1 Yes 2 No Bethesda Montgomery 3 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number 3 Funeral United States #817 20817 10250 Westlake Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2X No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. White If Yes, Give Specify: 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Higher Education Professor of English Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Likhtman Glukhman Klara Gregory 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is r any injury or other traum once. 20854 11929 Glen Mill Rd., Potomac, MD Vadim Shapiro / Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Durial 2XXCremation 3 Removal from State Chesapeake Crematory | 05/25/2011 4 Donation 5 Other (Specify) Beltsville, MD 21. Signature of Funeral Service Occasee

M0382

Rappe and Address all acidind Cremation
933 Gist Ave, Silver Spring

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Rabb and Cremation Services 20910 933 Gist Ave, Silver Spring, MD Approximate Interval Between Onset and Death Immediate Cause (Final Physician spiratory disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir and I-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): led by the attending physician a detached for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Fibrillation 2 No 3 Probably 4 Unknown ypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After Riatural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) May 24, 2011 D59013 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15825 Shady Grove Rd = 140 Rockille, MD 20850 Khludener MD Konstantin 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 26 2011 Registrar A. parket

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 1 1 1 6 8 3 1 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Cer	rtificate of	Death		Re	g. No.		
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last) Wilma	Spes				2. Date of Death Month May 22, 20	Day Year)11	3. Time of Death 0415 hrs	
`		4a. Facility Name (if not institution, give s 109 Forest Valley Drive			Forest Hill	r Location of Dea		4c. County of D		
Funeral Director		5. Social Security Number 6. Sex 216-09-9409 1 Number	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Day				Birthplace (State or Reign sylvani Country sylvani	
Aaryland 28a-f show any 1 at once.	or	Usual Residence of Decedent 10a. State 10b. County Md . Harfo		Town or Location					10d. Inside City Limits 1 Yes 2 X No	
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 301 Donald Circ	:le		10f. Zip Code 2105	0	10	g. Citizen of What G	-	
r death wi	/ Funeral	1 Never Married 2 Married 3 XWidowed 4 Divorced if	I2. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No Yes, Give Year	If Ye		n, Mexican, Puert	Specify Yes or No- o Rican, etc.)	14. Race - A White, et	merican Indian, Black, ic. White	
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner.	Completed by	15. Decedent's Education (Specify only Elementary/Secondary (0-12)	r Dates:	16a. Decedent during mo	's Usual Occupa est of working life	tion (Give kind of b. DO NOT use re	work done tired)	16b. Kind of Busine	ess/Industry	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica		8 th		Me	at Pac	18.Mother's Nam	e (First, Middle, M		's Meats	
2121 ould be fi Mental I	To Be	Hobart Downin 19a. Informant's Name/Relationship (Type	e, Print)	19b. Mailing	Address (Stree		L Mong Rural Route Numb	per, City or Town, S	state, Zip Code)	
10re, MD 2121 ages 1 and 2 should be fi nt of Health and Mental t: Witem 27 is marked other traumatic event,		Jovanna Tawney/ 20a. Method of Disposition					Deta T	Hill, I	Md. 21050	
Baltimore, permit. Pages la Department of He Importaot: If ite		1 Burial 2 Cremation 3 4 Donation 5 Other Specify: 21 Signature of Full states and Service Licenses	Не		Mary	Cem. 2	y 5,2011	Baltimo	re,Maryland	
Physician		23a. Part I. Enter the disease, or complica	ations that caused the death	12	01 Dun	dalk A	venue B	altimor	e, Md.21222	
/Medical xaminer		failure. List only one cause on each Immediate Cause (Final disease a. rig	line. pht hip fracture with co	mplications	o mode or dying.	- Jacon as cardiae	or respiratory arres	st, shook, of heart	Between Onset and Death	
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760, cate be executed physician and the burial - transit	/Medical	UNPENDED d.	AMENDED							
15	hysician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1								
P.O. Bc s that the des gned by the s	<u>~</u>	Part II. Other significant conditions co	9 Unknown ontributing to death but not re	esulting in the un	derlying cause	given in Part I.	23e. Did tob	acco use contribute	e to the cause of death?	
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Division of Vital tal or Atteoding Physiciae: rs after death. al Director: After this certiled in by the funeral director.	ation: T	27. Manner of Death 1 Natural 5 Pending 2 ✓ Accident Investigation	28a. Date of Injury (Month, Day, Year) Mar 5, 2011	28b. Time of Inj 0000 hrs		ry at Work? Yes 2 ✔ No	28d. Describe ho Subject fell	ow injury occurred		
Division To the Hospital or Atteod within 24 hours after death To the Fueral Director:	Certification:	3 Suicide 6 Could not be determined 4 Homicide Certifier Could not be	28e. Place of Injury - At ho (Specify) nursing hon		, factory, office b	ouilding, etc.	or Town, Sta		Rural Route Number, City t Hill, MD	
To the Ho within 24 h To the Fu	Medical	one) 2 ✓ Medical Examiner: On	To the best of my knowledge the basis of examination and manner stated.							
	ž	29b. Signature and title of certifier	Kd Th	(,,,)	29c. Licens O.C.			29d. Date signed ((Month, Day, Year)	
		30. Name and address of person who com Theodore M. King, Jr., MD.		•	00 W. Baltin	nore Street, E	Baltimore, MD	21223		
Sta Registr		31. Date filed (Month, Day, Year)	32. Legistrar's Signatur	har	41					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

	-	State Registrar		Cer	tificate of D	Death	R	leg. No.			
Physicia	n/	1. Decedent's Name (First, Middle, Last	•				2. Date of Deat Month May 22	Day Voor	3. Time of Death		
Medic	al	Cynthia Ruth 4a. Facility Name (if not institution, give s			Ab Oit Town on				10:31p M		
Examin	er	14 Rockdale Avenu	,		4b. City, Town, or	chville	11	4c. County of De	Harford		
Funeral		5. Social Security Number 6. Se	X 7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		9. E	Birthplace (State or Foreign		
Director	1	216-28-1289 Usual Residence of Decedent	82	Yrs.			03/03/	1929 M	aryland		
land f shov	tor	10a, State 10b. County	10c. City	, Town or Loc	ation				10d. Inside City Limits		
Mary 28a-1 ortifie	Director	Maryland Harfo	ord	Chur	chville				1 ☐ Yes 2 No		
ith the	la	10e. Street and Number 14 Rockdale Aver	3330		10f. Zip Code	1028		10g. Citizen of What (Country?		
ems 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	. 13. V	/as Decedent of Hi	spanic Origin? (S	pecify Yes or No-	USA 14. Race - An	nerican Indian,		
Wallyiallia 2 12 13-0030 2 should be filed within 72 hours after death with the Maryland 2 should be filed within 72 hours after death with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medi-al Examiner must be notified at	<u>S</u>	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 XX No If Yes, Give	- 1	Yes, specify Cuba		o Rican, etc.)	Black, Wh	nite, etc.		
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withir rgiene rer th:		12	College (1-4 or 5+)		hous	se wife		in :	home		
e filed tal Hy	To Be	17. Father's Name (First, Middle, Last)				_	me (First, Middle, N	,			
mark		Herman A. Coc 19a. Informant's Name/Relationship (Ty)		405. 14.35			R. Denbo		7.0.4		
Deficiency (Wat yield) A LA 13-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Misportant: If time AT is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		H. Wade Schneider	(son)		-			City or Town, State, 2			
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permit. Departing any inju		21. Signature of Funeral Service license	" I Indanh		Name and Addres		_	rgo Funer	al Home, P.A.		
		23a. Part 1. Enter the disease, or comp	ligations that caused the death					est,	Approximate		
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t the c	Physician/	9 Unknown	9 Unknown								
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aw required as been sig	Completed						24a. Was a		autopsy findings available		
he law te has age 2	ошо						autops perfori	med? prior to death'	o completion of cause of		
ian; T	BeC	25. Was case referred to nedical examiner?			26. Pla	ace of Death (Che	1 🗆 Yes	ZMNO ILLI	es 2 🗆 No		
hysic this ce	ပ္	1 🗆 Yes 2 🖰 No	Hospital: 1 ☐ Inpatient 2 ☐ I			4 ☐ Nursing I	Home 5 Reside	ence 6 Other (Sp.	ecify)		
ding Pl th. After th funera	Certificate:	27. Mann of Death 1 Natural 5 Pending	(Month, Day, Year)	28b. Time of injury	28c. Injury work M 1 \square	/at ? Yes 2□No	28d. Describe ha	w injury occurred			
VISIOII or Attendir fter death. irector: Af	ırtifi	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor			163 2 6 140		reet and Number or F	Rural Route Number,		
ital or ral Dir	_		building, etc. (Specify)				City or Town	n, State)			
Hosp 24 hou Fune eted fil	Medical	(Check 2 Medical Examin	ician: To the best of my knowle ner: On the basis of examination	and/or invest	igation, in my opinic	on, death occurred	at the time, date an	d place, and due to th	e cause(s) and manner stated.		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Σ	only one) 3 ☐ Certifying Nurs 29b. Signature and title of certifier	e Practioner: To the best of my	knowledge, c	29c. License			cause(s) and manner			
		DAT N	10.		10-	2066		127	11		
		30. Name and address of person who co	ompleted cause of death (Item)	23a) (Type, P	rint) to be	A	Helmina	1 (11 D		
Stat	e	31. Date filed (Month), Day, Year)	M. /2 607 ** Registrar's Signatu	ure _	Collor	54.	Havre	Up 5718	21078		
Stat Registra		NAY 26 2011	Aude A	hour	2				21-00		

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Charles F. Thompson	State of Maryland / Department of Health and Mental Hygiene

Physic		Registrar	Cert	tificate of	Deaui			Reg	. No.		
al Exam		1. Decedent's Name (First, Middle,Last) CHARLES F. THOM	OCON				2	Date of Death Month I May 19, 20	Day Yea		Time of Death 1145 hrs
		4a. Facility Name (if not institution, give si University Hospital			4b. City, Town, o	r Location of	Death	11.dy 10, 20	4c. County of	f Death	V
Eurora		5. Social Security Number 6. Sex	7. Age (In yrs. la	et hirthday\	If Under 1 Ye	ar If Under	24 ⊔ re	8. Date of Birth			ace (State or
Funeral Director					Months Da		Min.			Foreign	,
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Any		10a. State 10b. County	10c. City, 1	Town or Locat	ion					100	d. Inside City Limit
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faryla 28a-f laton	Director	10e. Street and Number			10f. Zip Code			10g	. Citizen of Wh	at Country?	,
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			2. Was Decedent Ever in U.S Armed Forces?		s Decedent of H						Indian, Black,
or its	臣	- 1	Yes 2 X No				dentore	can, etc.)			AN-AMERI
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filed within 72 I Hygiene. d other than " t, the Medical	្ង	17. Father's Name (First, Middle, Last)		LINII	CEL KENEO		Name (F	irst, Middle, Ma		STMES	3
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l and 2 s Health ar fitem 27		JUANITA THOMPSON (N		1095	C SUPER	IOR DE			RG PEN		
es la of He If its		1 X Burial 2 Cremation 3 X		ematory or oth		metery,		Jale	zoc. Location -	City of Tow	n, state
i. Pag tment rtant:		4 Donation 5 Other Specify:	PAX	TANG C	CEMETERY		5-26	5-2011	HARRIS	BURG,	PENNA
permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traus		21. Signature of Funeral Service Licensee	JONATHAN D. H								AL HOME,
ysician	_	23a. Part I. Enter the disease, or complica		7 04	N. FRO	NT ST.	STI	EELTON,	PENNA shock or hea	17113	pproximate Interv
Medical		23a. Part I. Enter the disease, or complicate failure. List only one cause on each	line Cardiorespi Implicating de	ratory brideme	arrest or oc	vith predure	coce for	eding br ournier	adycard	lia B	letween Onset and Death
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	miner		to (or as a consequence of):								·
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executed an and al - transit		d									
cate be execut physician and he burial - tra	n/Medical	X UNPENDED A	MENDED 23a, pt. II	1,27,28	Ba-f,per	me,g9	19 9	9-23-11	sm		
	/Me	OOK 18/as described assessed in the	23c. If yes, outcome of pregna						23d. Date of		
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ne death cer the attendined for use	Physicia		Unknown		_						
		Part II. Other significant conditions con Hypertensive Ather Bifascicular block	ntributing to death but not res	ulting in the u	nderlying cause	given in Part	l.	23e. Did toba	cco use contrib	ute to the o	cause of death?
at the d by tl	d by	Bifascicular bloc	k, status post,	cardia	c ablati	on dys	e plasi	a 1 Yes	2 No 3	Probably	4 V Unknown
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Kenneth Dale Warehime 2011 2013 hrs May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Harford Memorial Hospital Havre de Grace 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) EC . 3, 1954 217-60-2930 Maryland 56 Déc. Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location the Medical Examiner must be notified at death with the Maryland Director 1 🗌 Yes 2 🙀 No Cecil Maryland Port Deposit 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ō items 23a Funeral 18 Maple Hill Drive 21904 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc ō 1 Never Married 2 X Married \$ Maryland 21215-0036 hours after White If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: Specify: "natural" Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Freight Transportation Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil.
Department of Health and Mental
Important: If item 27 is marked of any injury or other traumatic ewe 2 Ralph Babylon Warehime, Sr. Jeannette Elizabeth Schueler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21904 18 Maple Hill Drive, Port Deposit, Maryland Brenda B. Warehime, Wife Baltimore. 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp: 5/25/2011 Towson, Maryland 22. Name and Address of Facility
McComas Funeral Home, PA 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysicianz Myocardia disease or condition Medical resulting in death) Due to (as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): ending physician are use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ō 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown been si should Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has b director, page 2 s autopsy performed? Yes 2 No 48er Tension 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗆 No ျ 1 Inpatient 2 PER/Outpatient 3 I DOA this 27. Mann f Death funeral 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at After work?
1 Yes 2 No iniury Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 (Check only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 201 D56888 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jamshid Mian, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are State of Maryland / Department of Health and Mental Hygiene	Legible,	10000
State of Maryland / Department of Health and Mental Hygiene	2011	10000
Certificate of Death	Reg. No.	

White, the part of	9. Birthplace (State or Foreign Country) SC 10d. Inside City Limits 1 Yes 2 No at Country? • A • -American Indian, Black, , etc. lack siness/Industry
4a. Facility Name (if not institution, give street and number) 5618 Purdue Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Director 5. Social Security Number 251-11-4678 1	9. Birthplace (State or Foreign Country) SC 10d. Inside City Limits 1 Yes 2 No at Country? • A • - American Indian, Black, etc. lack siness/Industry
Director 251-11-4678 Image: Amount of the part of t	Toreign Country) SC 10d. Inside City Limits 1 X Yes 2 No at Country? • A • - American Indian, Black, , etc. lack siness/Industry
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The survey of th	uction Co.
Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade na Construction Worker Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town 111 North Allendale Street, Ba 20a. Method of Disposition 1 J. Burial 2 Cremation 3 Removal from State	
12th grade na Construction worker construction worker land to the state of the stat	
John H. White Standard Stand	
19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Towr 19b. Mailing Address (Street and Number or Rural Route Number, City or Towr 19b. Mailing Address (Street and Number or Rural Route Number, City or Towr 11l North Allendale Street, Ba 20a. Method of Disposition 1 J. Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	
20a. Method of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)	1, State, Zip Code) 21229 1timore, Md
	City or Town, State
201. Method of Disposition Cremation Cremation Cremation Cremation Crematory or other place	s Mills, Md
March F/H West 4300 Wabash Ave, Baltimore,	Md 21215
Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.	Approximate Interval Between Onset and
Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):	Death
Sequentially list conditions.	
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Oue to (or as e consequence of): Due to (or as a consequence of):	
events resulting in death) Last Due to (or as a consequence of):	
events resulting in death) Last d. UNPENDED AMENDED OF STATE O	
TF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month	delivery Day Year
4 Pregnant at time of death 5 Other (Specify)	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	
1 Yes 2 ✓ No 3 24a. Was an 24b. W	Probably 4 Unknown Vere autopsy findings available
24a. Was an autopsy performed? 1 Yes 2 No 1 26 Place of Death (Check ask ask)	rior to completion of cause of leath?
Description of the property o	Yes 2 No
25. Was case referred to medical examiner? 1 Yes 2 No 1 Page of Injury 2	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 24a. Was an autopsy performed? If yes 2 No 1 25. Was case referred to medical examiner? 1 Yes 2 No 1 25. Was case referred to medical examiner? 1 Yes 2 No 1 26. Place of Death (Check only one) 27. Manner of Death 1 Yes 2 No 1 28d. Describe how injury occurred (Month, Day, Yaar) 28d. Describe how injury occurred (Specify)	∍d
O B T T T T T T T T T T T T T T T T T T	er or Rural Route Number, City
The state of the s	
Since the part of	as stated. ue to the cause(s)
29d. Date signature and title of certifier	ed (Month, Day, Year)
Octor Vater Jack O.C.M.E. May 19, 20	11
30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State 31. Date filed (Month, Day Year) 32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death willoughby Month cry Physician/ Jopa devo 13:20 M 2011 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Genera Itoward plumbia If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Age (In yrs. last birthday) 578-74-8960 1 □ M 2 👿 Months Yrs. **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MI 1 Ves 2 No toward slumbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2104 Irau 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 🖪 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည 110 10rman 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mart Woodland M rorest 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Surial 2 Cremation 3 Reproval from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Meadowridge 2612611 Signature of Funeral Service Lin Eunero Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ cree disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions. Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence on) the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of): resulting in death) Last the attending physician Division of Vital Records, P.O. Box 68760 tor: After this certificate has been signed by the attending p the funeral director, page 2 should be detached for use as IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mo*n*ths? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy 1 ☐ Yes 2 ☐ No 2 1 No Yes 25. Was case referred a medical 26. Place of Death (Check only one) examiner? Hospital 2 1 No Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner eath 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation after death Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Warss Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29c. License number 29d, Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20,2011 Ban HCGH , MD 54 ani. 31. Date filed (Month, Day, Year) 32. Registrar State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#23a, pt I, per PHYS, G917, 7/13/2011, WS

State of Maryland / Department of Bleakth and Mental Hygiene O For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year \mathbf{a}^{M} 4:08 2011 Medical Janice A. Weens May 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u>Baltimore</u> <u>Gilchrist Hospice</u> Towson 7. Age (In yrs. last birthday) Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 - M 2 X F 213-76-1494 500s Director 8-2-1960 MD Usual Residence of Decedent or 28a-f show and Mental Hygiene. 'is marked other than "natural", or items 23a or 28a-f shor raumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director n/a MD Baltimore 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 3802 Bartwood Road USA death permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Marianian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces ₹ 1 ☐ Yes 2 ☐ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married ò 1 Yes 2 No Specify: If Yes, Give 3 🗆 Widowed 4 🗆 Divorced Specify: African-American Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cashier Supermarket Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ပ Julius Weems Elaine M. Ortis Elaine H. Brown 19a Informant's Name/Relationship *(Type, Print)* Elaine H. Curtis Elaine M. Ortis/ Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3802 Bartwood Road, Baltimore, MD 21215 20a. Method of Disposition
1 □ Burial 2 🕅 Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Metro Crematory 5-31-2011 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Signal re of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate nterval Between months Death Immediate Cause (Final Physician/ metastatic lunc disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a cons Juence of To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 2 No the detached 1 ☐ Yes ∠ ■ 9 ☐ Unknown g Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available 24 hours after death. Funeral Director: After this certificate has autopsy performed? prior to completion of cause of death? page 2 2 No Yes 2 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 5 Pending (Month, Day, Year) 1 Natural 1 Yes 2 No М Accident Investigation the 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifie D007063 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ate 6 0) Char le 4105 31. Date filed (Month, Day, Year) State 26 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 23,2011 Physician/ 3:38P Howard Albert Wille, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Balto. Nottingham 9115 Kilbride Road 5. Social Security Number If Unde 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 1 X M 2 □ F 7. Age (In vrs. last birthday) **Funeral** Months Hours Count Maryland December 11,1935 75 Director 213-32-1425 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Examiner must be notified Nottingham Balto. Md. 1 Yes 2 X No 10f. Zip Code 9 10e. Street and Number 10a. Citizen of What Country? Funeral 23a 21236 uSA 9115 Kilbride Road permit. Page 1 and 2 should be filed within 72 hours after death \\
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner musonce. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 【 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. þ 1 Never Married 2 X Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Banker Bank 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary G. Hopkins Howard A. Wille 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9115 Kilbride Road Nottingham, Md. 21236 9115 Kilbride Road Jenevieve A. Wille Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Michael's 20a Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5-27-2011 Nottingham, Md. 4 Donation 5 Other (Specify) Schimunek Funeral Home 21. Signature of Funer Service Licensee 22. Name and Address of Facility Nottingham, Md. 21236 9705 Belair Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ rostate yeon disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No after death Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) e Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the pasts of examining on investigation, in my opinion, detailed to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 024356

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First Middle, Last) 2. Date of Death Month Physician/ Medical Name (if not institution, give street and number, 4c. County of Death **Examiner** 4b. City, Town, or Location of Death N/A BON SECOUR HOSPITAL BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) 5-20-1940 71 Days Hours Min. 219-36-8583 **Director** MARYLAND Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at **Funeral Director** MD. N/A BALTIMORE 1 X Yes 2 □ No 10e Street and Number ō 10f. Zip Code 10g. Citizen of What Country? items 23a USA 1010 W. BALTIMORE ST. APT 423 21223 Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. Ь 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates "natural", 1 Yes 2 No Specify. BLACK 3 ₩ Widowed 4 □ Divorced Specify: Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CONSTRUCTION <u>-12-</u> TRUCK DRIVER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ည JOHN HENRY WALLACE SR. MARY BEATRICE MACKALL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau MYRA WALLACE McCLOUD (DAUGHTER) 712 HAACK PLACE UPPER MARLBORO, MARYLAND 20774 20a. Method of Disposition
1 △ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 4 Donatton 5 Other (Specify) HOLLAND CEMETERY 5-28-2011 HUNTINGTOWN, MARYLAND e al Service Licensee 21. Signature of 22. Name and Address of Facility SEWELL FUNERAL HOME, P.A. 1451 DARES BEACH RD. PRINCE FRED., MD. 23a. Part 1. Enter the disease of shock, or heart failure. List of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death only one cause on each line. etastatic Immediate Cause (Final adenocarcinoma Drustall Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of). Be Completed by Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 9 Unknown Unknown P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? lancomycin resistant Enterococcus Division of Vital Records, 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' Yes 2 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ျှ 1 🗌 Yes 2 No 1 N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) in 24 hours after deau...

The Funeral Director: After the funeral process. 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 🔲 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier critifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only or 29b. Signature ar 2011 of person who completed cause of death (Item SOPNO 2000 WIST Balt Move STreet Saltmore

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State

31. Date filed (Month, Day, Year)

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 24 Day 011 Year Physician/ Month May В:40 р.м Isabella Josephine Wolfe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore County Greater Baltimore Medical Ctr Towson 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Months Days Min. 48 Mary and Director Usual Residence of Decedent rral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c, City, Town or Location with the Maryland Director Maryland Baltimore Timonium 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 272 Hunters Ridge Road U.S.A. 21093 filed within 72 hours after death val Hygiene.

d other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Divorced 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) N/A permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other t. any injury or other traumatic event, the once. N/A 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mollie Quay Woodward Timothy W. Wolfe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 272 Hunters Ridge Road Timonium, Maryland 21204 Timothy W. Wolfe / Father 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Hilltop Service Corp. 5/26/2011 1 Burial 2XXCremation 3 Removal from State Towson, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ O PLOSENCEPHAL disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) physician and the burlal-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day signed by the a Id be detached f 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 No 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No မ 1 Yes 1 Impatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending injury Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 25. selloeece 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BACTIMORE. HOWAN BIRENSAUM 6701 CHANCES STREET 31. Date filed (Month, Day, Year) State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 201 GM Medical Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City Examiner MOYE Hea are NIA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F (Month, Day, Year) 219-80-6739 Days Hours Min. Country) Director March Usual Residence of Deceden 10d. Inside City Limits ms 23a or 28a-f show must be notified at 10a, State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Nes 2 No altimos 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21216 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status ral", or iten Examiner Black, White, etc. Yes 2 Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural" Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+))r'sabl Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic evem 17. Father's Name (First, Middle, Last) မ mances 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcella HIMOLE 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State to Moro 1201 4 Donation 5 Other (Specify) Signatur of Funeral Service Li en 22. Name and Address of Facility Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence Hospital or Attending Physician: The law requires that the death certificate be executed -tran and Due to (or as a consequence of) resulting in death) Last the attending physician hed for use as the buria Physician/Medical Noung, Curtis LDivision of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Month Day Yes 2 No page 2 should be detached 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 1 Yes 2 No Director: After this certificate 1 Yes 2 No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 은 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 1 Inpatient 2 ER/Outpatient 3 D 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No □ Accident
 □ Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 24 hours a Funeral L Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Qentifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within To the only one) 29b. Signature and title ss of person who completed cause of death (Item 23a) (Type, Print) MD 21229 57 Jehavir Mees 31. Date filed (Month, Day, Year) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 7:34 PM Ann E. Young 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bultimore Sina: Hospital of Beltimore If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 🗓 F Months Davs 6-27-1929 Director 213-26-4260 Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Weden Event in a context on the context of t 10b. County 10c. City, Town or Location 10a, State 1X Yes 2 □ No Funeral Director Baltimore MDn/a 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6518 Eberle Drive 21215 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 1 No Specify Specify: African-American Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland Circuit Court 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Andrew Rock Clementine Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5708 Arapahoe Drive, Oxonhill, MD 20745 Denise Mahdi/ Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-26-2011 Baltimore, Mi Metro Creratory 22. Name and Address of Facility Wylie Funeral Home P.A. of Baltimore Co. 21. Sign Jure of Funeral Service License 9200 Liberty Road, Randallstown, MD 21133 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Complications **Physician** of Bladder Concer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if eny, leading to immediate cause. Enter Univerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hypertension Completed 24b. Were autopsy findings evailable prior to completion of cause of death? performed 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☑No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2011 D59062 24 M. A. Sm 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leltimore 21215 2401 W Belvedere M.A 32. Registrar's Signature filed (Month, Day, Year) State Barks Registrar 26 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 20多 720 Physician/ 2011 orman 05 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Da niversit 0 S timore Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 X M 2 □ F Days Country) 220-20-8410 8 MD **Director** Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 ☐ No ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code P 10g. Citizen of What Country? Funeral items 23a USA 21061 1224 CATHEDRAL DR. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Typ Yes 2 No
If Yes, Give Black, White, etc. "natural", or \$ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🙀 No 3 Widowed 4 X Divorced Completed Year or Dates WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SHIPYARD BOILER CLEANER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ and 2 should be other traumatic FARNELL YEAGER NELLIE BELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau BALTIMORE, MD 3808 8TH ST. MARY OCHS/NIECE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 5-25-2011 BALTIMORE, MARYLAND METRO CREMATORY ture of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest slock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ OID disease or condition Medical Examiner resulting in death) tate Sequentially list conditions, Examine Due to Lucas a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be attending physic for use as the b IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Box (Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No be detached 9 Unknown g Unknown Records, P.O. p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown 1 \square Yes Completed within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law autopsy performe death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be examiner? 2 X No မ 1 🗌 Inpatient 2 🕱 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Secertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balto, MD 21201 SIT Franklin 01 31. Date filed (Month) D 32 State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene [] State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MAY To, 2011 3:40 P M THERMON ALLEN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGES ACCOKEEK RESIDENCE, 18021 MERINO DRIVE Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** Hours 1**X**□ M 2 □ F MAY 28 1946 MISSISSIPPI Director 64 354-36-5818 Usual Residence of Deceden or 28a-f show notified at 10a State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MARYLAND PRINCE GEORGES ACCOKEEK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ral", or items 23a or Examiner must be Funeral 18021 MERTNO DRIVE 20607 UNITED STATES 12. Was Decedent Ever in U.S. Ayned Forces? 14 Yes 2 \square No 1965— If Yes, Give 1986 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 1986 Specify: BLACK Completed 3 Widowed 4 Divorced Year or Dates ed other than "natu event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) DEPT. OF THE ARMY Elementary/Seconday (0-12) 4 YEARS FEDERAL GOVERNMENT INTELLIGENCE SPECIALIST Mental Hygier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fileo Department of Health and Mental Hilmportant: If item 27 is marked ott any injury or other traumatic even မှ JAMES THOMAS ALLEN HELEN MARIE LEONARD ALLEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAMILLA ALLEN / WIFE 18021 MERINO DRIVE, ACCOKEEK, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State MARYLAND VETERANS CEM MAY 24,2011 CHELTENHAM, MARYLAND 4 Donation 5 Other (Specify) ture of Funeral Service Lineses THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 **JOHNSON** M00583 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Meto Immediate Cause (Final Small Cell Lyng Cancer Onset and Death Ph_sician/ disease or condition) Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and burial-trar Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🙀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 : autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 X No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify, 27. Manner of Death s after deaun.
al Director: After the Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending injury 1 Yes 2 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined 24 hours a Medical 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Texas M5800 MAY 11, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALTER REED ARMY MEDICAL CENTER 225741 Jethny 6900 GEORGIA AVENUE, N.W. WASHINGTON DC 20011

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Mildred Anspach May 2011 1750 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Dorchester General Hospital Dorchester Cambridge 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 **X** F Months Hours (Month, Day, Year) 10–15–1923 Director 196-18-3907 87 PA Usual Residence of Decedent or 28a-f show 10a. State 10b. County ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No MD Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 901 Talisman Lane 21613 **USA** 11. Marital Status 12 Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ρ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. White Specify: Completed 3 ▼ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Book Keeping Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clifford Akers Freida Hartfiel and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Health a if item 27 is Jeanne T. Norene (daughter) 901 Talisman Lane, Cambridge, MD 21613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Important: If I 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) any injury or Mid-Shore Cremation 5-10-2011 Cambridge, MD Foneral Service Lio Signature 22. Name and Address of Facility Mid-Shore Cremation Center by Colleen Curran-Bromwell, P.A. Cambridge, 23a Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Retween Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Lung Carcinoma) Medical Examiner Chronic Obstructive Lung Disease Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cachexia of Chronic Disease 1X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 X No 1 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No. Accident Investigation Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Registrar

Division of Vital Records, P.O. Box 68760

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30. Name and addre

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s of person Jeevan Errabolu

503 Byrn Street

MD

ho completed cause of death (item 23a) (Type, Print)

29c. License number

D69234

Cambridge, MD

29d. Date signed (Month, Day, Year)

5-10-2011

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® For State Amend 2 per phys, DOR, Registrar 5/16/11, LDB Certificate of Death 2. Date of DeatMay 1. Decedent's Name (First, Middle, Last) 5, 2011 3. Time of Death **Physician** Hnderson 8:35 AM. ane ratricia /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Market ienna brchester 8. Date of Birth (Month, Day, Year) if Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min 1 ☐ M 2 🔼 F 218-30-4603 Yrs Director Aug. 25, 1932 ennessee Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. It has the same 23a or 28a-f show tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it as Marical Experience. 1 AYes 2 No Director Vienna MID 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21869 USA Funeral Marke 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 If Yes. Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify. 9 3 Widowed 4 Divorced White Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) tate anager 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and M-Important: If item 27 in any lnjury or consequence. ၉ Vetter ava 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) St. Vienna MD21869 ou san Market 20b. Place of Disposition (Name of cemetery, crematory orpher place)
College Curron Bishwell Prantial Shore Cremation Ctr. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Cambridge, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Lenry Funeral 21. Signature of Funeral Service Licensee HOME, P.A. Henry Sio washington St. Cambridge, MD. 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mole of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) 00198) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pronary iner Due to (or as a consequence o): The law requires that the death certificate be executed Exami sician and burial-trans Due to (or as a consequence of) physician s the buriat Box 68760. Physician/Medical nding p use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant atter for u 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No as been si 2 should i Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page certificate 1 ☐ Yes 2 🖼 No of Vital 1 ☐ Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 🔲 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Medical Certification: To 28a. Date of Injury (Month, Day, Year) After t 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1 Accident Injury 5 Pending nours after death.

neral Director: Af
y filled in by the fur 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours af To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifle 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vorthe

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

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gue	be fill ttal Hy ad oth event	Be	17. Father's Name (First, John Blis		t)							l Unkn		umamo)		
Maryland	is 1 and 2 should be filed within 72 hours after death with the Maryland of theath and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	٩	19a. Informant's Name/F		(Type, Print)		19b. Mailir	ng Address	s (Street			al Route Numb	-	Town, State,	Zip Code)	21842
Ma	id 2 sith an traur	η W	Hahn T. N			riend	1261	0 Wh	isp	erino	a Wo	ods D	r.,	Ocean		
ē,	permit. Pages 1 and 2 Department of Health & Important: If item 27 i any Injury or other tra once.		20a. Method of Disposition	on		20b. P	Place of Dispo	sition (Nar	ne of	1		Date		ation - City or		
Baltimore,	Page nent o nt; If ry or		1 □XBurial 2 □ Cre 4 □ Donation 5 □								5/1	4/11	Ber	lin,	MD	
alti	permit. Page Department of Important: If any Injury or once.		21. Signat of Funeral	Service Lice	nsee J		22	2. Name an	nd Addre	ss of Facilit	ty E	Burbag	e Fu	neral	Home	
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			23a. Part . Enter the dis shock, or heart failu	sease, or cor ire. List only	nplications that ca one cause on ea	used the death ch line.	n. Do not ent	er the mod	de of dyir	ng, such as	cardiac	or respiratory a	arrest,		Approxima Interval Be Onset and	tween
Pro	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)		a. Seps											
4	Examiner		Togating in geatin,	4	1	or as a consequ	LIVEY	dis	seas	^ 43						
		Je.	Sequentially list condition if any, leading to immediate	ns, late	b. end Due to (STAGE or as a conjequ		O(13	3013	50		_				
	uted 1 ansit	Examiner	Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events		. Primo	ary s	clero	sing	cl	no lan	9. +1	5				
Ć.	exection and and inial-tra	M	resulting in death) Last		Due to (or as a consequ	uence of):	J)					
760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical			d											
687	ertifica ng ph e as t	sician/Med	IF FEMALE:		23c. If yes, out	come of pream	ancy							Data of de	- lineare	
Box	ath or ttend for us	cian	23b. Was decedent preg in the past 12 mont	ths?	1 Live b	irth 2 ☐ Feta ant at time of d	l death 3	Ectopic p Other (sp		y			2.	3d. Date of de Month	Day	Year
	he de the a ched	nysi	1 Yes 2 No 9 Unknown		9 🗌 Unkno											
, P.O.	v requires that the death been signed by the atter should be detached for	by Phy	Part II. Other significant	t conditions	contributing to de	eath but not res	sulting in the	underlying	cause g	iven in Part	1.	23e. Did	tobacco us	se contribute	to the cause of	death?
rds	quires sign uld be	ed b										1 🗆	Yes 2	3 □ F	robably 4 🗌	Unknown
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Ä	The la	Com				_						1 Tes	ormed? 2 ■ No	death?		
of Vital	rsician; The law s certificate has t director, page 2	Be (25. Was case referred to examiner?	medical	Hospital:				Oth	OKI		n (Check only o				
of	hysic this ce al dire	၉	1 Yes 2 No 27. Manner of Death		28a. Date	·	ER/Outpatier 28b. Time o		DA Otti	4 🗆 190	ursing Ha	me 5 Res			ecify)	
	or Attending Physician; after death. Director; After this certifics in by the funeral director,	Certification:		Pending investigati	(Mont	h, Day Year)	Injury	м	Wor		No					
Division	deatl ctor; by the	fica	3 Suicide 6	Could not determine	be 28e. Place	of injury - At ho		eet, factor	y, office	12/19/1			(Street and	Number or I	Rural Route Nu	mber,
Ö	al or / s after 1 Dire	Serti	4 Homicide		Dulldi	ng, etc. (Specify	y)					City of 10	wii, State)			
	To the Hospital or Attending Physician, within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.		29a. Certifier 1 U	Certifying F	Physician: To the aminer: On the ba	best of my kno	wledge, deat	h occurred	at the ti	me, date ar	nd place,	and due to the	e cause(s)	and manner and d	as stated. ue to the cause	a(s)
	the Hi in 24 the Fu	Medical	one)			ner stated.	1)		e number					nth, Day, Year)	
_	5 5 6 7 9	2	29b. Signature and title	of certifier		/				- 000	,		M			
			20 112	MA		no of doct //	m 02a\ /*:		V E 2	-000	j		14101	y 101	2011	
2	H 20+1	e 15	30. Name and did ess	person wh	no completed caus	Se or geath (Iter	m zsa) (Type	, Print)			600	North W	olfe St	, Baltim	ore, MD	, 21287
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	Regist	rar	A	AY 12	2 2011	Energe	B. 1	back	1							

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	Dharinin		1. Decedent's Name (First, Middle, L	ast)					2. Date of Dea Month		Year	3. Time of Death	
	Physicia Medic	al .			ncho	ff			May 13		- (D 15	7:38 A ^M	
~`` <u>`</u>	Examin	er	4a. Facility Name (if not institution, gi					r Location of Death		4c. County Wash	ingto	n l	
F. Segil Sequitive Number: 16 Sey 17 Age /le vire fast highday 1 If Under 1 Year 1 If Under 24 Hrs. 8 Date of Birth 9. Bit									g. Birthp	lace (State or Foreign			
	Director		213 -09-3340	1 □ M 2 📈 F	94	Yrs.	Months Days	Hours Will.	12/26/1	916	Mary	land	
	nd how at	l . I	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	cation				1	0d. Inside City Limits	
	farylar Ba-f s tified	Director	Maryland Washing	ton	Wil	liams;	ort					1 Yes 2 ☐ No	
	a or 2 be no		10e. Street and Number			-	10f. Zip Code			10g. Citizen of		try?	
	72 hours after death with the Maryland n "hatural", or items 23a or 28a-f sho Aedical Examiner must be notified at	Funeral	154 Artizan	12. Was Decedent E	uor in II C	12 \	21795	Hispanic Origin? (Spe	ecify Yes or No-	U.S.A	ce - Americ	an Indian	
10	or iter	by Ft	11. Marital Status1 ☐ Never Married 2 ☐ Married	Armed Forces?	ver iii 0.5 No	li li	f Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)		ck, White,		
036	rs afte ııral", Exan	ed b	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates.		1	Yes 2 No	Specify:		Specify	Wh:	ite	
2-0	2 hou "natu edica	Completed	15. Decedent's (Specify only highest		- 11	(Give	dent's Usual Occup kind of work done	during most of work	ing	16b. Kind of E	Business Inc	dustry	
Elementary/Seconday (0-12) College (1-4 or 5+) life. DO NOT use retired) 12 Supervisor Ge								Gove	Government				
Political Parameter Source (First, Middle, Last)								18. Mother's Nam	,	le, Maiden Surname)			
ರ ಕಕ್ಷಣ F Pierce MacNamee								Helen Nail					
Mar	2 should th and Me 27 is mar		19a. Informant's Name/Relationship	,,,,,		1		and Number or Rur			State, Zip (Code)	
d)	and and the Healt tem 2		20a. Method of Disposition	<u>Granddaught</u>	20b. P	lace of Dispo	sition (Name of	Ct. Abbin	Date Pil	20c. Location	- City or To	own, State	
D III	Page 1 ient of int: If i		1 🛣 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	Removal from State	1		natory or other pla		8/2011	Hagerst	own,	Maryland	
Baltimore,	permit. Page 1 a Department of I Important: If ite any injury or of		21. Signature of Funeral Service La	e) ee	,	22	2. Name and Addre	ess of Facility Re	st Haven	Tunera	al Cha	apel	
	20 E # 9		23a. Part 1. Enter the disease, or co	L-C	the death						Mary.	Land 21742 Approximate	
L			shock, or heart failure. List onl Immediate Cause (Final	y one cause on each line	. O	l. Do not ena	er the mode or dyr	No	11/10	,		Interval Between Onset and Death	
	Medical	П	disease or condition resulting in death)	a. Due to (or as a	consequ	ence of):	COL	1-RING	uly		_		
	Examiner	L	Sequentially list conditions,	b									
	sit sq	Examine	cause. Enter Underlying Cause (Disease or iinjury	Due to or as	a conse u	ence of							
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68760	rtificat ling ph e as th	Physician/Medica	IF FEMALE:	23c. If yes, outcome	of pregna	ncv				22d D	ate of deliv	en	
Box (eath certifice attending p	cian	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live Birth 4 ☐ Pregnant a	2 Feta	ıl death 3	Ectopic pregnarOther (specify)	ncy			lonth	Day Year	
9. B	the de by the ached	hysi	9 Unknown	9 Unknown									
, P.O.	Physician: The law requires that the death certificate be this certificate has been signed by the attending physici ral director, page 2 should be detached for use as the but		Part II. Other significant condition	s contributing to death b	ut not res	ulting in the i	underlying cause o	jiven in Part I.	23e. Did to	/		he cause of death?	
rds	equire	Completed by							24a, Was			ppsy findings available	
eco	e law e has k	Jung							auto		prior to co death? 1 \square Yes	ompletion of cause of	
E R	sician; The lav certificate has irector, page 2	Be Co	25. Was case referred to medical	.01			26.	Place of Death (Chec		202 [10]	1 1 103	2810	
Vit	Physicia this cer al direct	To B	examiner? 1 Yes No				nt 3 LI DOA		lome 5 Resid			y)	
Division of Vital Records,	ling Pl		27. Manner of Death Natural 5 ☐ Pending		ry y, Year)	28b. Time o injury	wo		28d. Describe h	now injury occu	rred		
Sior	al or Attending P s after death. I Director: After t d in by the funera	Certificate:	2 Accident Investiga 3 Suicide 6 Could not 4 Homicide determin	ot be 28e. Place of Injury			reet, factory, office		28f. Location (S	Street and Num	ber or Rura	l Route Number,	
Divi	tal or / rs after al Dire ed in b			building, et					City or Tov				
	Hospi 24 hou Funer sted fill	Medical	(Check 2 Medical Ev	Physician: To the best of aminer: On the basis of e	xaminatio	n and/or inves	stigation, in my opin	nion, death occurred	at the time, date a	and placé, and d	lue to the ca	ause(s) and manner stated.	
Tity or Town, State) 4 Homicide determined building, etc. (Specify) 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and Original Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and Original Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and Original Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and Original Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and Original Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and Original Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and Original Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and Original Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and Original Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and Original Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and Original Certifier Original Cer								29d. Date sign					
								133	05/	13	12011		
	13		30. Name and address of person w	ho completed cause of c	leath (Item	23a) (Type,				l		V	
	Cha	to	Shahid Mahmusa 31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	ture.	ne Hos	extorn	mp	21) 42		
	Sta Registr		31. Date filed (Month, Day, Year)	2011 Sens	m.	B. A							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month May 14 2011 Bernard Cyrus Barnhart 6:48 pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 11120 Lakeview Drive Hagerstown Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Min Hours 91 Director 215-14-2160 Pennsylvania Nov Usual Residence of Decedent 28a-f show 10a State 10h County 10c. City. Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 1 No Maryland Washington Hagerstown 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 9830 Downsville Pike 21740 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1

Yes 2

No
If Yes, Give

TATA Black White etc. ō 1 Never Married 2 Married Maryland 21215-0036 ۵ 1 ☐ Yes 2 No Specify: Year or Dates. WWII "natural", Specify: 3 M Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 0 Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Job Truax Barnhart Catherine Florence Andrews injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st.
Department of Health ar
Important: If item 27 is
any injury or other trau Wayne Barnhart 11120 Lakeview Drive Hagerstown, MD 21740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park May 19,2011 Hagerstown, Maryland Signature of Funeral Service Licenses Osborne Funeral Home P.A. Conococheague St. Williamsport, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Aortic stenosi Sequentially list conditions Examine Due to lor as a consequence of if any leading to immed cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last sician and burial-trans Due to (or as a consequence of): physician the burial Physician/Medical P.O. Box 68760 as attending p IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 1 Yes 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an s certificate has the autopsy performed 1 🗌 Yes 2 🗆 No 2 X No 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner' Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Son S Home 2 🔀 No 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 X Natural 5 Pending work To the Hospital or Attendia within 24 hours after death. To the Funeral Director; Ai completed filled in by the fu 1 Yes 2 No death. Accident M Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🖄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cartifie 29c. License number 29d. Date signed (Month. Day, Year) D67246 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

VACCATI

gistrar's Signature

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31. Date filed (Month, Day, Year,

1733

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Hazerstown

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day 2011 Year May 8:38 12 Physician/ Hilda Armel Brumbaugh Medical City, Town, or Location of Death 4c. County of Death Washington County 4a. Facility Name (if not institution, give street and number) **Examiner** Hagerstown 1055 Matthew Court 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 6. Sex Social Security Number Dec. 9, Virginia Days Hours Min. **Funeral** 1 🗆 M 2 💢 F 227-22-0575 85 Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f shov 10b County 10a. State should be filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 Yes 2 No Washington County Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 9 U.S.A. 21742 Funeral 23a 1055 Matthew Court Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. items 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Never Married 2 Married White 5 ģ 1 ☐ Yes 2 💢 No Specify Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 3 X Widowed 4 Divorced "natural", Completed permit. Page 1 and 2 should be filed within 72 hours a Department of Health and Mental Hyginen. Important: If item 27 is marked other than "natural any injury or other traumatic event, the Medical Exagone. 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Personal Residence Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Willie M. Carter Armel Louis E. Armel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1116 West Irvin Ave. Hagerstown, MD 21742 19a. Informant's Name/Relationship (Type, Print) Christine B. Ellis-daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rest Haven Cemetery 20a. Method of Disposition
1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Hagerstown, Maryland 5-16-2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition Pnysician resulting in death) Due to (or as a consequence of) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Ectopic pregnancy
 Other (specify) Day Month in the past 12 months? Pregnant at time of death 2 No ed by the g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed by page 2 should be detact by 3 Probably 4 Unknown 1 🗌 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed this certificate has Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? funeral director, Be Other: Hospital: 5 Desidence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 2 No Certificate: To 1 Tyes 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at 27. Manner of Death work? 1 ☐ Yes 2 ☐ No To the Funeral Director: After completed filled in by the funer 5 Pending Natural Accident
Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide after To the Hospital o within 24 hours af To the Funeral Di rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

redical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier ner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Certifying Nurse Practio only or 29d. Date signed (Month, Day, Year) License numbe of certifier 29b. Signat re and

JW-10 State

Registrar

30. Name and address of person

who comple

Please Type or Print in Black Indelible Ink. Ensure All Coples Are Legible. 11-03472 State of Maryland / Department of Health and Mental Hygiene Eugene Mitchell Brown, Jr Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month D May 9, 2011 0035 hrs Medical Examiner Eugene Mitchell Brown, Jr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Hagerstown Meritus Medical Center 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days Min Months Director 1 X M 2 F August 16, 1925 Washington 577-22-1650 85 Usual Residence of Decedent 10d Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 X Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injory or other tranmatic event, the Medical Examiner must be notified at once. Washington Hagerstown Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21740 USA 11 W. Baltimore St. Apt. 512 Funeral 14 Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 1X Yes Specify: Black If Yes, Giva Yaar or Dates: 1 Yes 2 X No specify 3 Widowed 4 Divorced \$ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) timore, MD 21215-0036 **Hotel** 12 th Bell Hop 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jessie Lee Dickens Be Eugene Mitchell Brown, Sr. 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ٩ 13503 Paradise Dr., Hagerstown, MD 21742 Stanley J. Brown, Sr./Brother 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Maryland National Cemetery May 13, 2011 | Laurel, Maryland Donation 5 Other Specify. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Gerald N. Minnich Funeral Home 305 N. Potomac St., Hagerstown, MD 21740 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. Hypertensive Atherosclerotic Cardiovascular Diseas /Medical Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit AMENDED 23a,pt.II,27,28a-f per me g917 7-20-11 vt Sa UNPENDED signed by the attending physician be detached for use as the burial -Physician/Medi Division of Vital Records, P.O. Box 68760, 23d. Date of delivery JE FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 2 Fetal death Day Year Live birth 3 Ectopic pregnancy Month past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions <u>á</u> 1 Yes 2 No 3 Probably 4 Unknown Hypertensive atherosclerotic cardiovascular disease, chronic renal failure, dementia Completed ficate has been si 24a. Was an 24b. Were autopsy findings available prior to completion of cause of this certificate has performed' death? 1 Yes Yes 2 V No 26.Place of Death (Check only one) 25. Was case referred to medical e Hospital or Attending Physician: 24 hours after death. director, Be Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other 2 ER/Outpatient 3 DOA 1 Yes 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 8c. Injury at Work? After 27. Manner of Death Certification: (Month Day Year) Subject aspirated liquid meal 1 Natural 5 Pending 1 Yes 2 ✔ No To the Funeral Director: completely filled in by the Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be determined (Specify) Nursing Home Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Ga 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier May 12, 2011 O.C.M.E. 5+1 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 JW

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

OCME

31. Date filed (Month, Day Year)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month () OAM Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pasadena Anne Arundel Holmes If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex . Age (In yrs. last birthday) 8. Date of Birth Funeral (Month, Day Days Hours Min. Maryland 1 - M 2 916 Jan Director 95 215-18-3159 Usual Residence of Decedent 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 28a-f shov 10a. State 10c. City. Town or Location filed within 72 hours after death with the Maryland al Hygiene. Director 1 ☐ Yes 2X No Anne Arundel Annapolis Maryland 10f, Zip Code 10e, Street and Number 10g. Citizen of What Country? USA 21409 2224 Mulberry Hill Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No à "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: Black 3X Widowed 4 □ Divorced Completed event, the Medical 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Community other than College (1-4 or 5+) Elementary/Seconday (0-12) Action Senior Agency 12th 0 Aid permit. Page 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumostical. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wesley Johnson Prudence Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21409 Barry White (Nephew 2224 Mulberry Hill Rd. Annapolis, Md. 20c. Location - City or Town, State 20a. Method of Disposition 2A.slouppysoBoroachneck Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-13-11 Annapolis, Md. U.M. Church Miname Research ScilitSons Mortuary, P.A. 21. Signature of Funeral Service Licenses 821 Annapolis, Md. West St. Lave 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Securitally list rondline if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) -transit or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last as the burialthe attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 in the past 12 mont Month Day 5 Other (specify) Pregnant at time of death g Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy has after death.

Director: After this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be completed filled in by the funeral director, examiner? Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner eath 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred 1 Latural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital or within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Modical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 3 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) 703 8 impleted cause of death (Item 23a) (Type, Print) Name and address of person who c 1445 DEFENSE HWY, ANNAPOLISH-D. 21401 FOOT-TAYLOR. JENEN I EUE GHT 31. Date filed (Month, 32. Red strar's Signature State 1 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marviand Bepartment of Mealth and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 03, 2011 Physician/ Bowden 6:36 P M Thomas John May Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center 9. Birthplace (State or Foreign Country) District of Columbia If Under 1 Year If Under 24 Hrs. Social Security Numbe Age (In yrs, last birthday) 8. Date of Birth Month, Day, Year) **Funeral** Hours Min 1 🛛 M 2 🗆 F 67 224-58-6495 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State at rector notified 1 X Yes 2 ☐ No Bowie Prince George's 28a-f Ö 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò ems 23a or r must be r USA Funeral 20715 12413 Shawmont Lane items 2 · death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S.
Armed Forces?
1 XYes 2 No
If Yes, Give Race - American Indian. "natural", or ite Black, White, etc. 1965 ģ 1 Never Married 2 X Married Maryland 21215-0036 hours after White 1 ☐ Yes 2 🔀 No 1969 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) within 72 and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Space Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, permit. Page 1 and 2 should be fill Department of Health and Mental Important. If item 27 is marked cany injury or other traumatic eve Mary Frances Holiday Thomas Frederick Bowden ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Laura Brooks Bowden / Wife 12413 Shawmont Lane Bowie, MD 20715 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May 07, 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Metro Crematory, INC. 21. Signature of Funeral Service Licensee CREMATION DIRECT 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter University Due to (or as a consequence of): Examine Cause (Disease or iinjury ON APPROVED BY MEDI that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician CERTIFICAT Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ Month in the past 12 months?
1 Yes 2 No Day for Pregnant at time of death cate has been signed by the a page 2 should be detached to 9 Unknown 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 100 3 Probably 4 Unknown 1 Tyes Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 X Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce 11 person who completed cause of death (Item 23a) (Type, Print) 30. Name an 5+ mth, Day, Year)
MAY 11 2011 31. Date filed (Month 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** :37 AM 2011 arnes Mas /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore City The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year June 2, 1 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 6. Sex **Funeral** 1 🕱 M 2 🗆 F Days Hours Min. 55 213-66-3359 Ĩ955 Ohio **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Maryland Anne Arundel Annapolis 1 ☐ Yes 2 X No Director 10f. Zip-Code 21401 10g. Citizen of What Country? 10e. Street and Number U.S.A. 180 Spring Place Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ऒ Yes 2 □ No If Yes, Give Year or Dates: 1980-85 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No White Specify Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Hospital Surgical Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Agnes Millacci James William Barnes, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 180 Spring Place Way Annapolis, Maryland 21401 19a. Informant's Name/Relationship (Type, Print) Mary Agnes Barnes/mother Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 5/10/2011 Baltimore, Maryland Baltimore Crematory 4 Donation 5 Other (Specify) eral rvide Licensee 21. Signature 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of) disease or condition resulting in death) Liffued large Cell lymphoma Medical Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and I for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director After this certifical completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Be Hospital: 1 Inpatient Other: 4 \square Nursing Home 5 \square Residence 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 6 Other (Specify) ၉ 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: il or Attending F s after death. 1 Natural 5 Pending investigation Injury 1 Yes 2 🗌 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 2011 5 RES-000

Registrar
DHMH 17 Rev 1/2001

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KONERMAN

32. Regist ar's Signature

MONICA

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 08^{Day} ${\tt May}^{\tt Month}$ Physician/ 0218 Edward Ε. 2011 Barnes Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Cheverly Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Feb 2 Days Hours 241-62-8554 67 1944 North Carolin **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified DC Washington 1 Yes 2 No 10e, Street and Number P 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral with 4407 E Street SE #4 20019 USA be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, er than "natural", or iter the Medical Examiner Armed Forces? Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black If Yes, Give Year or Dates Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DQ NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Industry Roofer 6th of Health and Mental Hygie If item 27 is marked other or other traumatic event, the Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Unknown Pattie Cora Daniels Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772Department of Health ar Important: If item 27 is any injury or other trau 13707 Carlene Drive Upper Marlboro Maryland Tricia Barnes (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20 1

Burial 2 □ Cremation 3 □ Removal from State Harmony Mem Pk CemMay 14,₁₁ |Landover Maryland 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Licer 22. Name and Address of Facility Tyrone Young Funeral 719 Kennedy Stréet NW Washington DC20011 23a. Part 1/ Enter the disease to shock, or heart failure. List ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death FATAL Physician disease or condition Medical resulting in death) Due to (or as a conseque ce of) Examiner 10 Sequentially list conditions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Exami burial-transi and Due to (or as a consequence of) attending physician for use as the burlal Physician/Medical death certificate be P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a d be detached f 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician; The law in 24 hours after death.
Funeral Director: After this certificate has be page 2 autopsy performed? 2 🗌 No 1 Tes Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) 2. No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ပ္ 1 Inpatient 2 R/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatu 29d. Date signed (Month, Day, Year, 2011 on who completed cause of death (Item 23a) (Type, Print) CHEVERLY MS 20 DAVIS

State Registrar 31. Date filed (Month, Day, Year MAY 1 2 2011

DHMH 17 Rev 7/2009

Registrar

Box 68760

PO

Records,

of Vital

Division

Amend Please Type or Print in Black/Indelible Ink. Ensure All Copies Are Legible.

1 - For Amend Items 23aPt1,25,27,28a-f per me,g922,12705/2011dhb

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Barbara Canto 2011 11:55 A May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Morningside House Waldorf Charles If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 1 F Yrs. Director 579-05-9677 91 31, 1919 Washington, D.C. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, The Medical Evan in a rough by nothing an 1X Yes 2 No Director Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2322 Kent Court 20602 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 Elementary/Secondary (0-12) College (1-4or 5+) 12th. Secretary Fed. Gov't 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be file hand Mental He is marked ott Be John Carow ೭ Gertrude Ripple 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sl
Department of Health an
Important: If item 27 is 1
any injury or other trau 2322 Kent Court, Waldorf, Maryland 20602
to of Disposition (Name of Date 20c. Location - City or Town, State <u> Iris Cross/ Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Huntt Crematory May 10, 2011 Waldorf, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, MD. 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Accident Fall disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine CERTIFICATION APPROVED BY MEDICAL EXAMINER requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical attending p use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day signed by the a 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Š 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy performed certificate 1 ☐ Yes 2 🗆 No Vital 1 □ Yes 25 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 DOther (Specific 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA o Certification: To 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Manh, Day, Year) 28d. Describe how injury occurred After Division Hospital or Attending Injury Natural Natural 5 Pending investigation death. 2 XAccident 04/14/2011**Unknown**^M 1 ☐ Yes 2 XNo Subject fell. Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 70 Village Street determined 4 Homicide Assisted Living Facility Waldorf,MD thin 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2BSt 702 31. Date filed (Month, Day, Year, 32. Redistrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Anna Marie COOPER MAT 7:30 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Jan. 27, 9. Birthplace (State or Foreign **Funeral** 1 M 2 X Days Min **Director** 213-40-3354 69 Maryland Usual Residence of Decedent or 28a-f shov 10a. State iral", or items 23a or 28a-f sho Examiner must be notified at with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1048 Georgia Avenue 21740 USA within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. "natural", or þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced white Completed Specify: Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than 'iury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) homemaker her own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Grant Wilson Norris Phebe Catherine Hollenbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Herbert Cooper, Sr.-husband 1048 Georgia Ave., Hagerstown, Md. 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 5/16/11 Hagerstown, Maryland Signature of Funeral Service Licens 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Opset and Death Immediate Cause (Final Physician/ umom disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Dav Year 2 10 No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 🔀 No Other: 1 🗌 Yes ျပ 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 Opal Court, HAGERSTOWN, MD 21740 Muhammad WASEEM 31. Date filed (Month Megistrar's Signature State MAY 13 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State AMEND#23E per PHY Registrar 5/18/2011 AAOO HE Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death Physician/ Month 5 Year 37 A M 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months 1 X M 2 □ F 85 14,1925 $\mathtt{July}^{^{(\!Month)}}$ New York Director 118–18–0473 Yrs. Usual Residence of Decedent 28a-f show 10b. County 10a. State must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Anne Arundel Severna Park 1 Yes 2 X No o 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral death with 232 Arundel Beach Road 21146 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. ıral", or iten Examiner ı Race - American Indian. Armed Force Black, White, etc. þ within 72 hours after 1 Never Married 2 Married ☐ Yes 2 🔀 No Maryland 21215-0036 White If Yes, Give 1 ☐ Yes 2 X No Specify. "natural", 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. d other than " Elementary/Seconday (0-12) College (1-4 or 5+) Church Deacon 5+ Be be filed permit. Page 1 and 2 should be flec
Department of Health and Mental Hy
Important; If item 27 is marked oth
any injury or other towns 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Madeline McKeon George L. Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marianne Harmon/ Daughter 232 Arundel Beach Road Severna Park, MD 21146 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of May 14 2011 20c. Location - City or Town, State cemetery crematory or other place)
Lady Queen of
Peace Cemetery 1 X Burial 2 Cremation 3 X Removal from State Royal Palm Beach, FL 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home ouce, 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Intended disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) YEARS Medical as a consequence of) Examiner 11 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to as a consequence of) 11 attending physician and for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Yes 2 No signed by the a ld be detached f 1 Yes 2 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 X No 3 Probably 4 Unknown Completed need 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 s autopsy performe page this certificate 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tyes 2 No ည 1 Inpatient 2 ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this funeral of 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident within 24 hours after death To the Funeral Director; / completed filled in by the f Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 0 Scott 31. Date filed (Month, Day, Year) MAY 1 1 2011 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	Claic of IV	C	ertificate			-	Reg. No		
	Physici	an	1. Decedent's Name (First, Middle, La		r Elizabe	th Clin	Cline 2. Date of Death Month			ath Da		3. Time of Death
- Au	/Media	cal	A- F-19h N- (11-4)- 11-11-11-11				2,	2, 2011 5:55 A				
*	Examir	er	4a. Facility Name (If not institution, given Homewood	ve street and number	4b. City, 1	4b. City, Town, or Location of Death Williamsport 4c. County of Death Washington					rton	
	Funeral Director		217-12-2660	Sex 7. A 1 □ M 2 □ F	ge (In yrs. last birthd 87	Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da May 2,	th ay, Year 19	9. Birthp Count 24 Max	olace (State or Foreign otry) cyland
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location					1	0d. Inside City Limits
	Mary a-f sh	tor	Maryland Washing	aton		S	Smitl	nsburg				1 ∐Yes 2 🔭 No
	or 28	Director	10e. Street and Number			10f. Zip	Code			10g. C	itizen of What Coun	itry?
	eath w	Funeral	11932 Comancl	ne Drive	Everin II 9	2 Was Doods		21783	poits Voc or No	. 1	U.S.A.	on Indian
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a fibrical Exemination must be notified at once.	by Fun	11. Marital Status 1 □ Never Married 2 □ Married 3 ¼ Widowed 4 □ Divorced	Armed Forces' 1 Yes 2 If Yes, Give Year or Dates:	No	If Yes, speci		spanic Origin? (Sp n, Mexican, Puerto Specify:	echy fes of No Rican, etc.))*	14. Race - Americ Black, White, & Specify: Wh	
5-0	"natu	letec	15. Decedent's E (Specify only highest gr	ducation a <i>de completed)</i>	(G	cedent's Usual	k done d	uring most of work	ing	16b. l	Kind of Business/Ind	dustry
72	withir jiene.	Completed by	Elementary/Secondary (0-12)	College (1-4or	5+)	e. DO NOT use I ns p	. ′			Воо	k Binding	Company
b	e filed al Hyg d other	Be C	17. Father's Name (First, Middle, Last	,				18. Mother's Name				
yla	nould b	ည	Chester Ye						aret Cl			
e, Mai	and 2 st tealth and m 27 is n her traur		19a. Informant's Name/Relationship Donald E. Cline	(Son)	53	Carib S	Stree	et Martin	sburg,	Number, City or Town, State, Zip Code) rg, West Virginia 25		
Baltimore, Maryland	t. Pages 1 tment of H tant: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of Control	fy)	20b. Place of Di cemetery, of Cavetow	n Cemet	ery	1 20	25, 11		avetown,	
Ba	permit Depar Impor any in		21. Signature of Funeral Service Lice		MO 14 14	22. Name and			-		Funeral	Home Land 21783
			23a. Part 1. Enter the disease, or com	pplications that cause	d the death. Do not						rg, margi	Approximate
11/20	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. END	574€ E s a consequence of):	Deme	NTI	4			- (Interval Between Onset and Death
Ī	Examiner		Sequentially list conditions	b	a sonsoquento oty.							
	ted isit	niner	Sequentially list conditions, if any least cause. Enter Underlying Cause (Disease or injury that initiated events		a consequence of):							
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89 2	ertifica ling ph e as th	Med	IF FEMALE:							-1	100	
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the buriat-transit	Physician/I	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown			3 ☐ Ectopic pre 5 ☐ Other (spe					23d. Date of delive Month	ery Day Year
S,	w requires that the d been signed by the should be detached		Part II. Other significant conditions	contributing to death I	out not resulting in the	underlying ca	use give	n in Part I.			use contribute to th	9.94
Records,	requir	Completed by	CECENT JUNG	My Fon	1) CHC	me 1	VEC	noil	1 🗆 '	Yes 2	2 ☐ No 3 ☐ Prob	bably 4 Unknown
Bec	ne law e has t ge 2 sl	mple	OF SMALL DOU	ec, sin	ANGULA	AS VA	4NA	Taum	24a. Was autop		24b. Were auto prior to cor death?	psy findings available mpletion of cause of
Vital	'sician: The law s certificate has l lirector, page 2 s	Be Co	25. Was case referred to medical	MALC (SC	our Va	since	ion	26. Place of Deat	1 □ Yes	2 N N		2 □No
<u> </u>	Physici this cer al direct	To B	examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpat	ent 2 ☐ ER/Outpa	tient 3 DO	A Othe				6 ☐ Other (Specify	y)
Division of	ding Ph h. After th funeral	ion:	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury 28b. Tim ay, Year) Injui	у	Bc. Injury Work	?	28d. Describe	how inju	ury occurred	
isi.	Attenc death ctor: y the i	ficat	2 Accident investigation 3 Suicide 6 Could not be determined		jury - At home, farm, tc. (Specify)	M street, factory,		es 2□No	28f. Location (Street a	and Number or Rura	l Route Number.
2	tal or safter al Dire	Certification:	4 Homicide determined	building, e	tc."(Specify)	,			City or To	wn, Stai	te)	,
	To the Hospital or Attending Physician: whithis 24 hours after death. To the Funeral Directors. After this certification in the funeral director, to the funeral director, the funeral director, the funeral director is the funeral director.	Medical	29a. Certifier (Check only one)	nysician: To the best miner: On the basis and manner s	of examination and/o	eath occurred a r investigation,	at the tim in my op	e, date and place, inion, death occur	and due to the red at the time,	cause(date ar	(s) and manner as s nd place, and due to	stated. o the cause(s)
	To t To t	≥	29b. Signature/shortifile by certifier	MEDICAL	Director	29c.	Jicense /	number 706		29d. D	ate signed (Mpnth,	Day, Year)
	2),		30. Name and address of terson who STEPHENE: METEN 31. Date filed (Month, Day, Year)	completed cause of	13424 Pa	Print)	751	101 HACO	EN Jall	v, i	We 21	142
	Sta Registr		NAY 2 6 2011	sua A.	facker facker	ľ						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician a** M 2011 MAY 2:00 CHRISTINE ANN DUFFY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 102 South Kent St. Chestertown Kent Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 ▼ F Yrs. Michigan 58 13, Director 372-60-1229 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Oppertment of Health and Mental Hyglent. In Page 11 flear 23a or 28a-1 show Important: If I flear 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Pedical Exteriner must be notified at yinjury or other traumatic event, the Pedical Exteriner must be notified at 1X Yes 2 □ No Director Chestertown MD Kent 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21620 102 South Kent St. U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ※No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White ģ If Yes. Give Specify: 3 ☐ Widowed 4 🙀 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Melvin Edward Duffy Gertrude Isabella Taube ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Walish, III (son) 102 S. Kent St. Chestertown, MD. 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Kent Cremation Services 5/23/11 Smyrna, DE. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service ²² Name and Address of Facility Home of Stephen L. Schaech Galena Funeral Home of Stephen L. Schaech 118 West Cross St. Galena, MD. 21635_____ ™00510 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or part failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C y se (Final disease o indition resulting in death) **Physician** /Medical Due to (or s a onsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Lines three injury cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. led by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown cate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 **N**0 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician; 26. Place of Death (Check only one) filled in by the funeral director, 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number

State Registrar

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DHMH 17 Rev 1/2001

29b. Signature and title of certifier

2011

NO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death A Physician/ Month 201 Rosa Rayetta DAVIS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Meritus Medical Center Washington Hagerstown If Under 24 Hrs. Social Security Number 1 Year 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛚 F Days Hours Min. March 28 1926 Maryland 85 Director 220-16-3238 Usual Residence of Decedent show ild be filed within 72 hours after death with the Maryland Mental Hygiene. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits , or items 23a or 28a-f sho iminer must be notified at Director 1 Yes 2 No Washington Boonsboro Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21713 8507 Mapleville Road "natural", or item ledical Exa⊓iner n 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🗶 No If Yes, Give þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. White Specify: 3 XWidowed 4 ☐ Divorced Completed Year or Dates 27 Is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Laundry Company Attendant Laundry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Floyd C. Myers, Sr. Grace Barton permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 Is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Lee Davis - Son 549 Guilford Avenue, Hagerstown, Maryland 21740 20a. Method of Disposition 1 █ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Rose Hill Cemetery 5/16/2011 Hagerstown, Maryland 21. Signature of Puneral Service Licensee 22. Name and Address of Facility Minnich Funeral Home Ε. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner that the death certificate be executed burial-transit Due to (or as a co Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ٥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 1 Yes 2 No 2 [Yes the Hospital or Attending Physician: hin 24 hours after death.

the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, 1 Yes 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural injury 5 Pending Accident Investigation the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Sigr 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 dell Registrar's Signature State

Registrar

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sandra Lynn Davis May 9 2011 11:39 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death 11565 Robinwood Dr. Apt22 Hagerstown Washington County If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** July 1, 1955 460-21-3388 1 M 2 X F Director 55 Pennsylvania Usual Residence of Decedent or 28a-f show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Washington County Hagerstown 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11565 Robinwood Dr. Apt 22 21742 U.S.A. should be filed within 72 hours after death v and Mental Hygiene. 'Is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 N No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 ☐ Never Married 2X Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Student College Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Brown Donna V. Norris Brown permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mar any injury or other traumat 19a. înformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John E. Davis-husband 11565 Robinwood Dr. Apt 22 Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Kremation 3 Removal from State 4 Donation 5 Other (Specify) Smithsburg Crematory: 5-11-2011 Smithsburg, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Douglas A, Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ Circhosi disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical JE FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 performe 2 🗌 No 1 Yes Yes 2 No ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 XNo Other: 1 Tes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital c within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1342 Pennsylvania Ave., Hagerstown, MD Steven Hatleberg, MD 21742 Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760

Records,

Division of Vital

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 14, 2011 1:45 pM Newton K. Deibert Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Washington Autumn Assisted Living Hagerstown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Days Hours Min. May 2, 1920 Months Pennsylvania **Director** 91 180-16-6032 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Fairplay Maryland | Washington 10f. Zip Code ò 10e. Street and Number 10g. Citizen of What Country? ıral", or items 23a o Examiner must be Funeral 21733 USA 9029 Jordan Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?

1 X Yes 2 No Black, White, etc. and Mental Hygiene.

is marked other than "natural", or i raumatic event, the Medical Examin 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: 3 X Widowed 4 □ Divorced Completed WWII White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Deibert Newton Lottie Ε. Kimmel Α. permit. Page 1 and 2 should be Department of Health and Ment Important; If item 27 is marke any injury or other traumatic toce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9029 Jordan Rd. Fairplay Maryland 21733 Lynn P. Deibert (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of West Brunswick Twsp. 1 ★ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) Kimmels Evang. Free Gem. 5 | 19 | 11 | Pennsylvania 4 Donation 5 Other (Specify) 21. Si atu of Pherical de vice troe see 22. Name and Address of Facility Osborne Funeral Home P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a. Fart T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ a ARTERIO SCLEROTIC CARDIS VASCULA disease or condition Medical resulting in death) Due to (or as a consequence of): DISEASE 7 Ris Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Examir The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): nding physician ause as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Dav Year ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed k 23e. Did tobacco use contribute to the cause of death? δ WYPERKIPIDE MIA ANENIA 1 Yes 2 No 3 Probably 4 Unknown Completed CO FONARY ARTERY DISEASE ALZHRIMERY 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? DISEASE Yes 2 Wind Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) HOTUMP A SISTED examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft. Completed filled in by the fur work 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) alt wo P18019 16,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 340 mill 5T. HACERETOWN MD mb gistrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ϋ́ΑΜ DENNIS DANNER SR. DERYLMedical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner CIVISTA MEDICAL CENTER Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Min. APR 9 1 XXM 2 A F 57 Director 238-94-0666 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Directo CHARLES WHITE PLAINS MD 10e. Street and Number 10f. Zip Code 10g Funeral 9345 BILLINGSLEY ROAD 20695 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 XMarried ģ Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give 72-192 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16 (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)
5 + HISTORIAN U Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maid ည BETTY JEAN S GEORGE CLAUDE DANNER JR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Ci 9345 BILLINGSLEY RD., WHITE KYONG DANNER / SPOUSE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 200 MAY Date 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State METRO CREMATORY 23,2011 A 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licens 22. Name and Address of Facility RAYMOND 5635 WASHINGTON AVE., LA M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Diabelisn disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the hurial-transit Exam resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobac δ Records, 1 Tes Completed 24a. Was an autopsy performed Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate 28c. Injury at 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? ours after death.

neral Director: Af
filled in by the fu 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street City or Town, St determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause (s Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause (s Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause (s Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause (s Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause (s Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause (s Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause (s Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause (s Certifying Nurse Practioner: To the best of my knowledge). 29a. Certifier 29c. License number 0 43306 29b. Signature and title of certifier C BATON G MP YZZS ALTAMONT PL SUITE 201 WH SYLVIB BATONGMP 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

No.2011	16868
20 20°1′1	3. Time of Death 7:03 AM
4c. County of Death	
CHARLES	
	ace (State or Foreign
10	0d. Inside City Limits 1 □ Yes 2 ^X No
Citizen of What Count	
14. Race - America Black, White, e	tc.
Specify: WHIT	?E
o. Kind of Business Ind	ustry
.S. AIR H	FORCE
len Surname) ETZER	
or Town, State, Zip Co	^{ode)} ID 20695
LEXANDRIA	
NL. SERVI PLATA, MI	CE,P.A. 20646
	Approximate Interval Between
	Onset and Death
23d. Date of deliver	Y Day Year
co use contribute to the	e cause of death?
2 No 3 Prob	ably 4 🗆 Unknown
24b. Were autopoprior to com	sy findings available apletion of cause of
death?	
e 6 Other (Specify) njury occurred	
and Number or Rural F ate)	Route Number,
) and manner as stated ace, and due to the caus se(s) and manner as stat	se(s) and manner stated.
Date signed (Month, D	
HTE PLAINS	no 20195

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month 1 Day 2011 4:15 AM May Physician/ Mildred Virginia Exum Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Caroline Denton Caroline Nursing Home g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 7. Age (In yrs. last birthday) Maryland 5. Social Security Number (Month, Day, August 29 **Funeral** 1 □ M 2 □XF Director 219-16-2247 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County or 28a-f shov 10a. State "natural", or items 23a or 28a-f sho Director 1 X Yes 2 No Henderson Caroline Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. Funeral 21640 Lot 40 16800 Henderson Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. filed within 72 hours after death Black, White, etc. Armed Forces? 1 Never Married 2 Married þ Specify 1 Tes 2 No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates White 3 Widowed 4 Divorced Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation marked other than "natur matic event, the Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Family Homemaker 12 H.S. Grad. 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Winifred Isabell Wells item 27 is marked o ပ္ Charles Dent Herb Page 1 and 2 should be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Hughesville, Maryland 20637 6225 Cracklingtown Road Michael Prater/nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ₽ = 1 X Burial 2 Cremation 3 Removal from State Denton, Maryland May 17, 2011 permit. Page Department of Important: If any injury or Denton Cemetery 4 Donation 5 Other (Specify) Moore Funeral Home, P.A. 22. Name and Address of Facility Signat Denton, Maryland 21629 12 South Second Street or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final d:11 a teg Cardianyoga Physician/ disease or condition resulting in death) Due to (or as a consequence of) Medical **Examiner** Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury s been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ Year Month Day in the past 12 mont Pregnant at time of death 2 No 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown OPD Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 s performed Yes 2 2 🗌 No 1 Yes Yes this certificate 26. Place of Death (Check only one) 25. Was case referred to medical Division of Vital Hospital or Attending Physician: completed filled in by the funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 No မ 28c. Injury at 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28h. Time of 27. Manner of Death Certificate: 24 hours after death. Funeral Director: After 1 Natural 5 Pending 1 Yes 2 No М Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be Suicide 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) the within 7 29d. Date signed (Month, Day, Year) 29c. License number Signature and title of certifier 29b. D0053255 CM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3683 Chaptonk Rd Proston MD Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 U 1 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12/8 A M ai Barbara J. Faulk 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Lanham Doctor's Community Hospital . Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea Iay 19, 1 1 □ M 2 🛂 F Days Hours Min. 099-30-7943 74 May Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 🔀 Yes 2 🗌 No Maryland Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20774 United States 208 Kendle Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc 2 X No 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Specify: Black 3 🗷 Widowed 4 🗌 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Government 12th Microfilm Technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Muriel Carson Norman Woodland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20774 19a. Informant's Name/Relationship (Type, Print) 13207 Keverton Drive Upper Marlboro, Maryland Andre R. Faulk - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Maryland Veterans
Cemetery 1 A Burial 2 Cremation 3 Removal from State 18 2011 May 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Maryland 22. Name and Address of Facility 21. Signature of Furreral Service Licenses Stewart Funeral Home, Inc. *** 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4001 Benning Road NE Washington, DC 20019 Immediate Cause (Final Onset and Death disease or condition Urosepsis resulting in death) Due to (or as a consequence of): <u>Respiratory Failure</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) <u>Pneumonia</u> that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe Yes 2 X No 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 XNo 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred **X**Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed use as the burial-transit attending physician Box 68760 for hed by the a P.O. sate has been signed page 2 should be de Records, within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, i of Vital Hospital or Attending Physician: Division

Physician/

Medical

Director

Funeral

Completed by

Be

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Examiner

Funeral

Director

"natural", or items 23a or 28a-f shov edical Examiner must be notified at

pertrit. Page 1 and 2 should be filed within 72 hours Degratment of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Bonce.

Physician/

Medical

Examiner

Examine

Physician/Medical

by

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Certificate:

Medical

29a. Certifier

(Check

only one 29b. Signatuk

and title of certifier

death with the Maryland

72 hours after 21215-0036

Baltimore, Maryland

To the within 2 20

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elizabeth Fasika, M.D. 8118 Good Luck Road Lanham, Maryland 32. Registrats Signature

🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MD060925

29d. Date signed (Month, Day, Year)

May 9, 2011

20706

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 U 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 05978 2011 2:12 Рм Mae Fisher Violet Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wicomico Parsonsburg 32812 Willomet Court 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🛛 F Hours 03406 17977 Vi**ra**Thia Director 94 215-16-3857 Usual Residence of Decedent 28a-f show 10b. Count 10c. City, Town or Location or items 23a or 28a-f sho miner must be notified at 10d. Inside City Limits Director Parsonsburg 1 Yes 2 YNo Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21849 Willomet Court 32812 within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. \$ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours afte. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify. Specify: 3 X Widowed 4 Divorced Completed White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Buyer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mae Taylor Harry Thomas Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32812 Willomet Court, Parsonsburg, MD 21849 Patricia Parker|daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evergreen Cemetery 20a. Method of Disposition 20c. Location - City or Town, State . Page 1 g 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05 | 12 | 2011 |Berlin,Maryland Signature of Funeral Service Licenses HOLLOway Funeral Home P.A. 501 Snow Hill Rd., Salisbury, Maryland 21804 bompro CFSP 23a. Part 1. Enter the disease. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the bunal-transi Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? 4 Pregnant at time of death 9 Unknown Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No death? 1 Yes 2 No ☐ Yes To the Hospital or Attending Physician: 1 within 24 hours after death. To the Funeral Director: After this certifics 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 2 X No Other: 욘 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🏿 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medica! Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as statted. 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year)

STE

Maryland 21215-0036

Baltimore.

Box 68760

P.O.

Records,

Division of Vital

State Registrar

DHMH 17 Rev 7/2009

address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 23° 2011 Gardiner 5:33 A^{M} David Carlson Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick 5807 <u>Meadow Road</u> 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Maryland (Month, Day, Year) av 28, 1934 1 X M 2 □ F Days Hours Min Months 76 **Director** 217-30-6376 May Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Frederick Frederick Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21701 5807 Meadow Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status med Forces Black, White, etc. 1 Never Married 2 Married þ 2 No 1 X Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) within 72 should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Painter Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Margaret Leather Plunkard Carlson David Gardiner 1 and 2 should b of Health and Mer fitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5807 Meadow Road, Frederick, Maryland 21701 Ruth C. Gardiner / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott May 26°. cemetery, crematory or other place) 1 🛛 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) 2011 Bethesda U.M.C. Cemetery Damascus, Maryland Z^{2. Name and Address of Facility} Reeney and Basford PA Funeral Home of Funeral Service Licensee M M01473 106 E. Church Street, Frederick, MD 21701 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ist only one cause on each line. 23a. Part 1. Enter the diseas Approximate Interval Betw shock, or heart failure Onset and Death Immediate Cause (Final er/Cerma Wandre Physician/ homic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to numerilate cause. Enter Underlying Cause (Disease or iinjury Due to for as a some equation of the Exami and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical death certificate be Box 68760 the ! 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 5 Other (specify) Pregnant at time of death signed by the a detached g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 1NO 3 Probably 4 Unknown Records, 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an the Hospital or Attending Physician: The law r hin 24 hours after death. the Funeral Director: After this certificate has b page 2 autopsy Yes 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Tyes ER/Outpatient 3 DOA 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes Certificate: 1 Natural 28d. Describe how injury occurred injury 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie pleted (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 3 [29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 46B Thomas Johnson Drive, #200, Frederick, MD 21702 Simon Kai Kairouz. M.D. Sebastien 32. Figistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2011 900 PM VIAC Gree /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Healtho RIJOWA MS Hal Washing es If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F 216-03-5687 97 Director 17, 1913 Maryland Aug. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at Weste 1 ☐ Yes 2X No Director Virginia Berkeley Falling Waters 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25419 44 Gethesemane Street USA Funeral ral", or items ? Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2**XX**No Specify: Specify: Completed by alth and Mental Hygiene.
127 is marked other than "natural";
er traumatic event, the Medical Exa 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ۵ Charles Ricker Emily Curtis Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any injury or other troones. Edward Hyne-Nephew 4269 Orion Path Liverpool, New York 13090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery May 11,2011 Baltimore, Maryland 21. Signature of Juneral Source Runeral Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) zheimer Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlansit mansit. Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by tension 1 🗌 Yes 2 No 3 Probably 4 Unknown certificate has teen si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 ☐ Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

State Registrar 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

29c. License number

Marsh P. Ke Hajustown MD 21742

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 434 AM 2011 MAY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** City, Town, or Location of Death 4c. County of Death hestertown Ken ester If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Min Hours Delaware 214-70-5482 53 Director Yrs Usual Residence of Decedent 23a or 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Funeral Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-fs any injury or other traumatic event, the Medical Examiner must be notified 1 Yes 2 XNo Sudlersville Oueen Annes MD 10e. Street and Numbe 10g. Citizen of What Country? USA 21668 6210 Sudlersville Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married XYes 2 ☐ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Maintenance Janitor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Calvin Gibbs Evelyn Sudler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6210 Sudlersville Rd. Sudlersville, MD21668 Marian B. Gibbs 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Crem. Serv 5/20/2011 Wyoming, Delaware 4 Donation 5 Other (Specify) Summit 22. Name and Address of Facility Pippin Funeral Home, Signature of Funeral Se Licensee 119 W. Cam-Wyo Ave., Wyoming, 19934 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause n each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy page 2 should be detached for in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 9 Unknown 9 Unknown rificant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other sign 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes Yes filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural injury 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after death To the Funeral Director. Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatu and title of certifie (2000) 15 ess of person who completed cause of death (Item 23a) (Type, Print) WA

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State Registrar 31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

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	State of Maryland / Department of H	ealth and Mental Hygiene	

		1- For State Registrar		Certific	ate of	Death			Red	a. No.			
Physicia edical Exami		1. Decedent's Name (First, Middle, Last) Geraldine Ruth Griffin 2. Date of Death Month Day Year May 19, 2011									ar	3. Time of Death 1430 hrs	
		4a. Facility Name (if not institution 103 W. Inca Street	on, give street and num	ber)	4	4b. City, Town, or Location of Death Aberdeen				4c. County Harford			
Funeral Director		5. Social Security Number 219-72-9031	6. Sex 7	. Age (In yrs. last bir	rthday) Yrs.	If Under 1 You Months Da	ear If Ur ays Ho	nder 24Hrs urs Min	_	•	Foreig	thplace (State or In untry) Maryland	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a nr 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No 15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation during most of working life. It Cashier 17. Father's Name (First, Middle, Last) 18. Was Decedent Ever in U.S. 19. No 1 Yes 2 No 1							(Give kind of work done O NOT use retired) Sales Mother's Name (First, Middle, Maiden Surname) Beulah Thelma Temple and Number or Rural Route Number, City or Town, State, Zip Code) Street, Aberdeen, Maryland 21001 ery, Date 20c. Location - City or Town, State 05/24/2011 WestChester, Pennsylva Facility Zellman Funeral Home, P.A. 210				
Physician Medical Examiner 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in jury that infloated events resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):									t, shock, or he	art	Approximate Interval Between Onset and Death		
ords, P.O. Box 68760, w requires that the death certificate be example as been signed by the attending physician should be detached for use as the burial.	by Physician/I	X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Unit Part II. Other significant condit Fatty Liver;	23c. If yes, our 1 Live birth 4 Pregnan 9 Unknown ions contributing to d	t at time of death n eath but not resultin	2 Feta	al death 3 er (Specify)	Ecto	oic pregna	23e. Did tob: 1 Yes 24a. Was an	2 No 3	Dioute to temporary Proba	he cause of death? ably 4 Unknown opsy findings available	
DIVISION Of VITAI REC. spital or Attending Physician: The la nours after death. neral Director: After this certificate he filled in by the funeral director, page 2	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 29a. Certifier (Check only one) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date May 20, 30. Name and address of person who completed cause of death (Item 23a)								esidence 6 No 1 sidence 6 No 1 winjury occurr eet and Number lee) s) and manner d place, and d	urred mber or Rural Route Number, City ner as stated. d due to the cause(s) gned (Month, Day, Year)			
Sta Registi	ate		istant Medical Ex		V. Baltin	nore Street	Baltim	ore, MD	21223				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Nancy Jane Gruber 6:20AM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Meritus Medical Center Hagerstown Washington County 7. Age (In yrs. last birthday) 62 vre Date o. (Month, E 5. Social Security Number If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🔀 F Months Days Hours Min 218-50-2734 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Co. Hagerstown 1 ☐ Yes 2 K No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1412 Outer Court U.S.A. 21742 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married XX Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates Specify: White 3 - Widowed 4 - Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 1 and 2 should be filed within of Health and Mental Hygiene. item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Data Entry Ribbon Mfg. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည David R. Miller Anna D. McClay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. Gruber / Husband 1412 Outer Court, Hagerstown, MD20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State Smithsburg Crematory 5-22-2011 Smithsburg, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Puysician disease or condition resulting in death) aldiac Medical Due to (or as a consequence of): Examiner Leudomembra Sequentially list conditions, Examine if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury or Attending Physician: The law requires that the death certificate be executed sician and burial-trans. that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death Other (specify) detached g 🗌 Unknown 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 No Yes 2 No completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Matural 5 Pending injury 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I 3 29b. Signature and title of certifie 2011 145 P 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AHERD 12821-31. Date filed (Month, Day, Year) 32. Registrar's Signat

DHMH 17 Rev 7/2009

Registrar

26 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 20 ^{ay}2011 Thelma Elizabeth Gornall 7:50AM™ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany The Chateau Cumberland Social Security Number **Funeral** 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 WV 8. Date of Birth 1 M 2 Hours Director Nov 23 215-26-6836 81 Usual Residence of Decede 28a-f shov 10a. State aţ 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Directo 10d. Inside City Limits must be notified WV Mineral Fort Ashby 1 XYes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 109 Jamie Street 26719 USA items one of Mental Hygiene. imarked other than "natural", or iten imatic event, the Medical Examiner! Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married <u>6</u> Yes 2 No Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Completed 3 XWidowed 4 Divorced Specify white Year or Dates Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+ Service Representative Southern Bell Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve 2 William Clay Smith Lola B. (Swick) Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Richard Gornall 14029 Canal Road SE Cumberland MD 21502 step-sor Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Memation 3 Removal from State cemetery, crematory or other place: Scarpelli Funeral Home, PlA. 5/21/2011 4 ☐ Donation 5 ☐ Other (Specify) Cresaptown MD 21. S'onature of Funeral Service License 22. Name and Address of Facility Paral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Enter the disease, 23a. Part . Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Other (specify) Month Year Day detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ be Completed 2 No 3 □ Probably 4 □ Unknown 1 Yes page 2 should has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 🗌 No 1 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? 2 2 No 1 Inpatient 2 I ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Defitying Projections to the basis of examination and/or investigation, in my course at the time, date and place, and due to the cause(s) and manner stated.

2 Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 705 CarrIN 10000

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

26

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 May Bessie Vestal Howard 10:30 A.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u>Sunrise Assisted Living</u> <u>Frederick</u> Frederick If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 1 □ M 2 🔀 Days Hours Sept. Day 9 225-38-4859 83 .1927 Tennessee Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 605 B Berryrose Court 21701 death v Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural" Specify: White 3 ₩ Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Ms life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert H. Hawk Grace Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Anne H. Blough (Daughter) Stine Court, Middletown, MD 21769 Baftimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department o Important: If any injury or once. ò 1 Burial 2 XCremation 3 Removal from State Smithsburg Crematory 5/23/2011 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee & Basford P.A. Funeral Home Church St., Frederick, MD 21701 MO1612 23a. Part 1 Inter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) em babso out manam Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause Futur Uncarlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Hospital or Attending Physician: The law requires that the death Year Month Day Pregnant at time of death 5 Other (specify) the detached 9 Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Disease Completed Cosonon 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has I funeral director, page 2 s autopsy performed' Yes 2 No 1 Yes 2 No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 \square Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1. Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu death. 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only on Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur d title of certifier Thomas Thousan DY e and address of person who completed cause of death (Item 23a) (Type, Print) 65 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month EVELYN PHILLIPS HURLEY 10:43 8 Medical Facility Name_(if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death WICOMICO 115bur If Under 1 Year Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 □ M 2 👿 F Months Davs Hours (Month, Day, Y Vear Maryland Director 216-09-1138 95 1915 Usual Residence of Decedent or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Pocomoke City MD Worcester 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1924 Cedar Hall Road 21851 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Yes 2X No Baltimore, Maryland 21215-003 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: White 3 😾 Widowed 4 🗆 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 11 <u>Bookkeeper</u> Petroleum Supply Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Emma Outten Alonzo Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1210 Westview Terrace, Dover, DE 19904 Sandra Klima/ Niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) First Bapt. Cem. 5/13/2011 Pocomoke City, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Holloway Funeral Home, P.A. Pocomoke City, MD 21851 107 Vine St 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death CADION YOPATHY Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner BUIRN T Sequentially list conditions, it any same to increase cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year signed by the a ld be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has ral director, page 2 performed Yes 2 🗆 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 Other (Specify) 2/1 No 1 🗌 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred After iniury 5 \square Pending Natural Accident Investigation after death Director: / in 24 hou. the Funeral Dire.. Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month. Day, Year, D0058410

BA5

State Registrar SACSBURY NO 2/802

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

MAY 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 5 35AM 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington If Under 24 Hrs. 8. Date of Birth (Month, Day, March 18, 5. Social Security Number 6 Sev 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours 1 X M 2 □ F 164-42-1526 Coatesville, PA Director 60 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 Yes 2 No Director MD Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21740 USA 333 Henry Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Me No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💆 No Baltimore, Maryland 21215-0036 Specify: Specify: Completed by 3 Widowed 4 Divorced **Black** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hyglen Important: If item 27 is marked other thi any Injury or other traumatic event, the once. Assembly Worker Truck Manufacturer 12 th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pearl Moore Leo Hendry, Sr. ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) <u>Joyce E. Hendry / Wife</u> 338 Henry Ave., Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 17, 2011 | Coatsville, PA New Evergreen Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac St., Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) patic **Physician** /Medical Due to (o as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner he law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by phalopath 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed 2 **№** No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ▼No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation s after dea. 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

within 24 hours are...

To the Funeral Director

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Name and address of person who completed see of death (Item 23a) (Type, Print)

4014 Maish Pike Hapristown MD 21742

5-11-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 9 2011 Marie Terese Heacock 3:30 A Medical a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington County Loyalton of Hagerstown Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 89 Days Hours Min. Minnesota 1 M 2 XF Months 472-14-7283 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County Funeral Director Maryland Washington County Hagerstown 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20009 Rosebank Way 21742 U.S.A. 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Completed by 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Year or Dates. Specify: White 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Congressional Aide Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Peter Baltes Mary Mader Baltes 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Heacock-son 11246 Suffolk Dr. Hagerstown, MD 21742 20a. Method of Disposition
1 □ Burial 2 🛣 Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Smithsburg Crematory 5-11-2011 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart follure. List only one cause on each line.

Immediate Cause (Final Interval Between Onset and Death Physician/ ADV ANCED TORMINIM MONTHS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner MONTHS -FALLURIE 10 TITRIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy death? 1 ☐ Yes 2 ☑ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 🙀 No 1 Yes ASSISTED LIGHT 1 Inpatient 2 ER/Outpatient 3 IDOA ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 134656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

CHA ZALA

31. Date filed (Month, Day, Year)

VH-10

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

(com)

MI

1190

egistrar's Signature

HARBUSOWN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month <u>Barbara Ann HENLEY</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Meritus Medical Center Hagerstown If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Ye 1 M 2 X F Months Days Hours Min. 75 Director 217-30-7152 Feb. 1936 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland | Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11218 Lakeside Drive 21740 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Hygiene. other than "natural", If Yes, Give White 3 Midowed 4 □ Divorced Specify: Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 0 Her own home <u>Homemaker</u> marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental ည Unknown Ruth Virginia Haines Hollenbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>.s</u> permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is 12027 Kemps Mill Road, Williamsport, Md. 21795 Daniel Henley - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Cedar Lawn Mem. Park 5/11/2011 Hagerstown, Maryland Signature of Puneral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Chronic Obstructive Pulmoney Immediate Cause (Final Physician/ disease or condition resulting in death) Over 10 years Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, loading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, 2 No 3 Probably 4 Unknown cate has been signage 2 should h Completed ronic renal failure, mild 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Fueral Director: After this certificate has be the Fueral Director: After this certificate has be completed filled in by the funeral director, page 2 s autopsy 1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, it may opinion, seating control as the state of the cause (s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier D0045563 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12916 Conamar Drive, Suite 204, Hagerstown, Maryland 31. Date filed (Mor State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mav 2011 Ricky Lee Harbaugh, Sr. 4:38 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>Suburban Hospital</u> Be<u>thesda</u> Montgomery 8. Date of Birth (Month, Day, Dec. 29 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 X M 2 D F Hours 52 Director 220-76-6527 Maryland Usual Residence of Decedent 28a-f shov 10a, State 10h. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 954 Lanvale St. 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Š 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) Hygiene. College (1-4 or 5+) 12 th Truck Driver Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ဂ္ Richard Dick Harbaugh Louise Onetta Schetrompf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health Linda M. Harbaugh / Wife 954 Lanvale St., Hagerstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 05/15/2011 | Smithsburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac St., Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ph sician/ Acute Myocardial Infarction disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Litter or denying Cause (Disease or linjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) ending physician use as the burial Physician/Medical 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Year Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' Hospital or Attending Physician; The Yes 2 No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital: 2 No 1 🗌 Yes Other: ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred - Natural 5 Pending ☐ Accident 24 hours at er death Funeral Director: A Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30. Name and address of person tho completed cause of death (Item 23a) (Type, Print) DIWC George Rd Belles Na MARIN 8 600 CKRMODY 16 20 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Humbertson Violet Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death WMHS-RMC Allegany Cumberland Birthplace (State or Foreign Country)
 MD 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Funeral 8. Date of Birth 1 M 2 DF Mar²4 ^{Ye}f⁄927 Director 213-22-3660 84 Usual Residence of Decedent or 28a-f shov notified at 10b. County 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Allegany MD Little Orleans 1 □xYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe items 23a oner must be Funeral 13007 Appel Road NE 21766 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or itel þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the waitress Restaurant Be t. Page 1 and 2 should be filed rtment of Health and Mental Hy rtant: If item 27 is marked oft jury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ethel (Appel) McDonald Martin Harry McDonald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 8726 Avondale Road Baltimore MD 21234 Philip Humbertson son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Martin Cemetey 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or 5/23/2011 MD Little Orleans 4 ☐ Donation 5 ☐ Ogher (Specify) Signature of Funeral Se vice Licensee 22. Name and Address of Full Full Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. P. 1. Enter the distance, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Cardio Dulmon Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
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Unknown sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 MNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe After this certificate 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 No 은 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural work? 1 ☐ Yes 2 ☐ No Accident 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a
To the Funeral C 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 5/18/11 (Wmp cumberland 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABOUL HANAN CHEEMA 12500 Willow brook 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 16885 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Thomas Cotter Immer 10:50 PM May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1020 Oak Hill Ave Washington Hagerstown 5. Social Security Number If Under 2 9. Birthplace (State or Foreign Country)
Chevy Chase, M 8. Date of Birth **Funeral** 1 🛛 M 2 🗆 F Month, Day, ne 18, Months Davs Hours Min **Director** 220-40-3112 67 June Usual Residence of Decedent 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 No Washington Hagerstown 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1020 Oak Hill Ave. 21742 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc 1 Never Married 2 X Married δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene, is marked other than ' Elementary/Seconday (0-12) 12 College (1-4 or 5+) Cowboy / Rancher Beef and Meat Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic even ျှ <u>Charles A. Immer</u> <u>Ellen Cotter</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Flaherty Immer / Wife <u>1020 Oak Hill Ave., Hagerstown, MD 21742</u> 20a. Method of Disposition
1 ☐ Burlal 2 ♣ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Smithsburg Crematorium May 13, 2011 | Smithsburg, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Gerald N. Minnich Funeral Home Signature of Funeral Service Licenses 305 N. Potomac St., Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as à consequence of) Exami attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 1 Yes 2 9 Unknown 9 Hinknown P.O. | Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 Yes 2 No 25. Was case referred to medical Division of Vital funeral director, Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27, Mann ≠ of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred atural 5 Pending 1 Yes 2 No Accident after death Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of amination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the birst of my knowledge, death oncum d at the time, date and place, and due to the cause(s) and marker as stated 29b. Signature and title of certifier 30. Name and address of person who completed to se of death (Item 23a) (Type, Print) JW 8

DHMH 17 Rev 7/2009

State Regis<u>trar</u> 31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HARRY D. JOHNSON MAY 2011 7:30 A^{M} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SENATOR BOB HOOPER HOUSE FOREST HILL HARFORD Social Security Number If Under 1 Year If Under 24 Hrs . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 X M 2 D F Hours 1926 84 SEPT 17. 220-20-2818 Yrs Director MARYLAND Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City. Town or Location with the Maryland 10d. Inside City Limits Director 1

Yes 2 □ No MARYLAND HAVRE DE GRACE HARFORD 10e. Street and Number 10g. Citizen of What Country? must be I Funeral 816 N. JUNIATA STREET 21078 UNITED STATES 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. "natural", or iter Armed Forces? Black, White, etc. þ 1 Never Married 2 Married If Yes, Give 1945–46 1 ☐ Yes 2 X No Specify: BLACK 3 X Widowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 Elementary/Seconday (0-12) 12 College (1-4 or 5+) the CHIEF ELECTRICIAN US GOVERNMENT other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked HARRY THEODORE JOHNSON CLARISSA JOHNSON Page 1 and 2 should thent of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shu Department of Health an Important: If item 27 is any injury or other trau MICHELLE COOPER / DAUGHTER 387 STRATFORD AVENUE, ABERDEEN, MARYLAND 21001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 💢 Burial 2 □ Cremation 3 □ Removal from State LARKS UNITED METH 5/14/11 4 Donation 5 Other (Specify) BEL AIR, MARYLAND 21. Signature of Funeral Service Licensee LISA SCOTT FUNERAL HOME, P.A. 552 LEWIS STREET, HAVRE DE GRACE, MD 21078 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STAGE Physician/ CONGESTIVE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last Physician/Medical for use as IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medica Be completed filled in by the funeral director, 26. Place of Death (Check only one) Hospital 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural injury within 24 hours after death.

To the Funeral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and Mile ss of person who completed cause of death (Item 23a) (Type, Print) JUNE State Registrar

TOTANGON I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Carlee Ned Keys Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 205 11th St. Unit 6 Ocean City Worcester Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 1 🛛 M 2 🗆 F Hours 55 10720/1955 Director 218-68-7886 "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director MD Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 205 11th St. Unit 6 21842 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 ♣ Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 K No Specify: Completed 3 Widowed 4 Divorced Year or Dates. AF 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) US Air Force Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Ned Keys Ida Painter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosa Painter (Aunt) 13 Joseph Gallaher St. Elkton, MD 21921 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State cemetery, crematory or other place) First State Crematory 5/12/2011 4 Donation 5 Other (Specify) Millsboro, DE 21. Signature of Funeral Service License 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin.MD 21811 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has Yes Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical æ 26. Place of Death (Check only one) 1 ¥ Yes 2 □ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate; 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical

DUYH

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100 ECarwil Registrar's Signature

21801 W

death? 1 Yes 2 No

29d. Date signed (Month. Day, Year)

3. Time of Death

M

1320

Birthplace (State or Foreign Country)

MD

Approximate erval Betweer

Onset and Death

10d. Inside City Limits

1x Yes 2 No

Year

11

DHMH 17 Rev 7/2009

29a. Certifie

(Check

only one 29b. Signatur

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

450497

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Medical Examiner Adam Lee KELLEY

4a. Facility Name (if not institution, give street and number) Month Day May 7, 2011 1110 hrs 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 24Hrs. Director Months Days Hours Country 214-88-2034 1 X M 2 F 28 Yrs Aug. 31 1982 Indiana Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show hours after death with the Maryland Maryland 1 X Yes 2 No Washington Director Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1060 Matthew Court 232 21742 Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc Yes 2 X No Widowed Divorced 4 If Yes, Give Year \$ Yes 2 X No specify. Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done it. Pages 1 and 2 should be filed within 72 hou. runnt of Health and Mental Hygiene. "Lant: If litem 27 is marked or or other traum." Completed 16b. Kind of Business/Industry Elementary/Secondary (0-12) during most of working life. DO NOT use retired) College (1-4 or 5+) 12 0 Sales Associate Retail Sales 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Gary L. Kelley Janelle Wipf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary L. Kelley - Father 1060 Matthew Court, Hagerstown, Maryland 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Burial 2 X Cremation 3 Removal from State Department o Donation 5 Other Specify Hagerstown Crematory 5/9/2011 Hagerstown, Maryland 21. Signa une al l'uneral Service License 42. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 20a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line /Medical Between Onset and a Subdural Hematoma Immediate Cause (Final disease Examine Death or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Discase or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical UNPENDED attending physician or use as the burial AMENDED The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy past 12 months? Month Day Year Pregnant at time of death 5 signed by the atte Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ Yes 2 ✔ No 3 Probably 4 Completed Unknown 24a. Was an 24b. Were autopsy findings available has 2 s autopsy prior to completion of cause of performe death? certificate Yes 2 V No 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Hospital: 1 / Inpatient 2 Other 4 this 1 🗸 Yes ER/Outpatient 3 2 DOA Nursing Home 5 Residence 6 No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) May 6, 2011 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred Natural Operator of moped that ran into a stopped 0230 hrs Pending Funeral Director: 1 Yes 2 ✔ No 2 🗸 Accident Investigation vehicle in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State)
E. Washington St. at Locust St., Hagerstown, MD determined (Specify) Local Street Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. g 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Delv ered O.C.M.E. May 9, 2011 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day,

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gistrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May Month William E. King, Jr 12 Day 201 Year 9:38 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 12918 Cathedral Ave. Washington County Hagerstown Social Security Number 6. Sex 1 X M 2 □ F If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth No. 19,1925 215-20-7734 Months Min 85 **Director** Maryland Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Washington County Hagerstown 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral 12918 Cathedral Ave. 21742 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 7 944Year or Dates. 1946 1 Never Married 2 Married Black, White, etc. Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) President Bank Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ William E. King Bertha M. Schwartz 1 and 2 should be of Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betsy M. King-daughter 12918 Cathedral Ave. Hagerstown, MD 21742 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Rest Haven Cemetery 5-17-2011 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown. MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Por not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Interval Betweer Immediate Cause (Final Onset and Death Physician/ Bladde-Meterbas disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 Yes 2 L 9 Unknown signed by the a d be detached fi Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires t within 24 bruns after death.

To the Funeral Director, After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 0 41667 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JW 141 MClorneck 11110 nedical 31. Date filed (Mo State Registrar

DHMH 17 Rev 7/2009

Records, P.O. Box 68760

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Jane Koontz 20 1 1 P^{M} May 7:20 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 21137 San Mar Road Boonsboro Washington Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Age (In yrs. last birthday) Funeral 8. Date of Birth (Month, Day, 1 □ M 2X F Days Hours Min 90 Director 1920 214-14-6012 Maryland Nov. Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Washington Boonsboro 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21137 San Mar Road 21713 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc ğ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No "natural", Specify: White Completed 3X Widowed 4 ☐ Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) other traumatic event, the 10 Seamstress Textile Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F marked o Bernard Repp Goldie Mann permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sonja L. Blair/Daughter 16559 Conovale Dr., Hagerstown, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rest Haven Cemetery 5/16/2011 Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complicat ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury Due to (or as a consequence of): that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 | Accide 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier 29c. License number <eese 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JW-4

Registrar

DHMH 17 Rev 7/2009

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21742

			Please	State of Mary							lible.	16001
		-	For State	State of Mary		•	e of Death	iu iviei i				10001
			Registrar 1. Decedent's Name (First, Middle, Last)		erincai	e or beauti	2.0	Research atte of Death	g. No.		3. Time of Death
	Physicia	n/	Thompson A	: : /	Victo "	11-			lonth 5	Day 2	Year O 1	5:49 PM
_ 、	Medic Examin		4a. Facility Name (if not institution, give s		7001	4b. City,	Town, or Location of D			4c. County	of Death	
1			Baltimore VA	Medical C	enter	Ba						
	Funeral		5. Social Security Number 6. Se:		yrs. last birthda	Months	r 1 Year If Under 24	Hrs. 8. D	ate of Birth Month, Day, Y	(eap)	9, Birthp Coun	place (State or Foreign try)
	Director		215-56-4212		60 Yrs	·.		107	/15/1	950		MD
	and show I at	1.1	10a. State 10b. County	100	c. City, Town o	Location					1	0d. Inside City Limits
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	h the ka or be n	a D	10e. Street and Number			10f. Zi _l			10	g. Citizen of USA	What Cour	ntry?
	th wit ms 2; must	Funeral Director	61 Front Street	12, Was Decedent Ever i	in II S		915 dent of Hispanic Origin	2 (Specify V	es or No-		ce - Americ	an Indian
	or dea	by Fu	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 🔀 Yes 2 🗌 No	III 0.5.	If Yes, spe	cify Cuban, Mexican, P	uerto Rican	, etc.)		ck, White,	etc.
21215-0036	rs afte iral", Exan	ed b	3 Widowed 4 X Divorced	10 N - Oi -	68-71	1 🗌 Yes	2 No Specify:			Specify	, wn:	ite
5-0	2 hou "natu edical	Completed	15. Decedent's Ed (Specify only highest grad		(0		rk done during most of	working	1	6b. Kind of E	lusiness In	dustry
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d 2	ed wi Hygie other ent, tl	امها	12 17. Father's Name (First, Middle, Last)		1 500	er wor		Name (Firs	t, Middle, Ma	aiden Surnam		
an	be fill lental rked tic ev	욘	Thompson A. Lyon	II			Mabel					
Maryland	should and N is ma		19a. Informant's Name/Relationship (Ty	oe, Print)			S (Street and Number o			City or Town,	State, Zip (Code)
Σ	nd 2 sealth m 27		Michael A. Lyon -				oad, Elkto	n, MD				
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 🔼 Cremation 3 ☐	Removal from State		crematory or	other place) 05	5/21/2	011	0c. Location		
ij	ift. Pag irtmer ortant njury		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Se		R.T.Foa		eral Home,			Rising		
Ba	Depa Impo any i		21. Signature of Futural Set at License	Keon	10		orge Stree					
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	Medical Examiner		resulting in death)	a. Due to (or as a cor								
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9289	eath certificate b attending phys ifor use as the l	Physician/Medi	IF FEMALE:									
9 x	th cer ttendii or use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of po	Fetal death	3 Ectopic					ate of deliv onth	ery Day Year
Вох	e dea the a	ysic	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at tim 9 ☐ Unknown	ne or death	5 Other (s	pecify)					
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Records,	tw require as been si 2 should	plet						_	24a. Was an	/ I	prior to co	psy findings available empletion of cause of
Rec	The law cate has page 2 s	S							perform 1 Yes 2		death?	2 No
ta	sician: The certificate I rector, page	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of Death					
of Vital	Physic this cral dir	2	1 ☐ Yes 2 No 27. Manner of Death	1 Inpatient 28a. Date of injury	2 ER/Outp		OA 4 Nursi 28c. Injury at			nce 6 Oth		/)
n o	ding Fith. After a funer	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Ye	ear) inju	ıry M	work? 1 ☐ Yes 2 ☐ N			, ,		
Division	l or Attend after death Director: A	Certificate:	3 Suicide 6 Could not be 4 Homicide determined			, street, facto	y, office	28f. I	Location (Stre	eet and Numl	ber or Rura	l Route Number,
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	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 5 Medical Evami	ician: To the best of my ner: On the basis of exam	ination and/or i	nvestigation, in	my opinion, death occu	irred at the t	ime, date and	place, and d	ue to the ca	use(s) and manner stated.
	othe	ž	only one) 3 L Certifying Nurs 29b. Signature and title of certifier	e Practioner: To the best	t of my knowled		c. License number	nd place, an		ause(s) and n		
	L S F O		17-	MD		1	124787	461	6	5-	15-	2011
	11. 8		30. Name and address of person who o	completed cause of death	ı (İtem 23a) (Ty	pe, Print)	- 1			14	40	
_			Thomas Silmes		N. C	reen	e 5t.	Bac/	171116.	e, N	10	(120)
	Sta Registr		31. Date filed (Month, Day, Year) MAY 9 6 2011	32. Registrar's	Signature	•	·					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienefor State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month M44 Day Grayson Josephus <u>Michael</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Meritus Medical Center Hagerstown Washington Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Days Hours Min. Months 89 Maryland **Director** 220-16-2399 Usual Residence of Decedent show 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Frederick Smithsburg Maryland 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21783 USA 13224 Wolfsville Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian armed Forces?

1 ☑ Yes 2 ☐ No
If Yes, Give
Year or Dates. 42-45 Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12 College (1-4 or 5+) Farmer General Farm Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Solomon Michael Catherine Palmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 13224 Wolfsville Road, Smithsburg, Maryland 21783 Brent Michael/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) St. Mark's Lutheran May 25, 2011 Wolfsville, Maryland 504 Main Street 21. Signaline of Fineral Service 22. Name and Address of Facility Myersville, MD 21773 Ricketts Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Dementia disease or condition resulting in death) Medical Due to (or as a consequence of): [']Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (bisease or injury Due to (or as a consequence of): sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 2 🗆 No been signed by the should be detached 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform certificate 1 Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) ၉ 1 Nonpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number D3847

DHMH 17 Rev 7/2009

State Registrar

3/1

Jeffyrson Blud 5mithsburg MD 21783

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO 229/6

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Please	Type or Pri	nt in I	Black In	delible In	k. Ensure	All Copie:	s Are	e Legible.	
		For		State of M	arylan			Health and I	Mental Hy	giene	nii	16893
		State Registrar				Cer	tificate of I	Death		Reg. No	CUII.	10000
Physicia	n/	Decedent's Name (I		,					2. Date of De		ıvYear	3. Time of Death
Medic	al	Michael Wi							Мау	8		2:07 M
Examin	er	Southern M	_				4b. City, Town, o	r Location of Death	1	- 1	:. County of Deatl	
Funeral		5. Social Security Num			e (In yrs. Ia	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt			hplace (State or Foreign
Director										59 Wash	ington,D.C.	
nd how at	'n	Usual Residence of De 10a. State 1	ecedent 0b. County		10c. City	, Town or Loc	ation				10d. Inside City Limits	
larylar 3a-f s iffied	Funeral Director	Maryland Charles				Waldo	rf					1XX Yes 2 □ No
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r item		11. Marital Status 12. Was Decedent Eve Armed Forces?					Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Amer Black, White	
s after al", o Exam	d by	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Never 1 Never					☐ Yes 2X☐ No	Specify:			Specify: White	
hours natur dical	Completed		15. Decedent's Ed fy only highest grad		9//-	16a. Deced	ent's Usual Occup			16b. K	(ind of Business I	ndustry
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d with	Be C	12th. 17. Father's Name (First	nt Middle Last)			Mecha	nic				<u>utomotiv</u>	e
be file ental i ked o c eve	To E	Joseph Mea				18. Mother's Nan	ne (First, Middle, thy Tril		,			
and Me s mar s mar		19a. Informant's Name		oe, Print)		19b. Mailin	a Address (Street	and Number or Rui				Code)
id 2 st salth a n 27 is er tra		Sheryl Mea	ars/ Wife	9				e Lane, V				. 3000)
of He If item		20a. Method of Dispos		Removal from State	20b. P	lace of Dispos	sition (Name of natory or other place		Date		ocation - City or	Town, State
t. Pag tment tant: jury c		4 Donation 5	Other (Specify	Removal from State	Hunt	tt Crem	natory	May 1	4, 2011		aldorf,	MD.
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funer	al Service License	2	h ATT	22.	Name and Addre	ss of Facility Hu	intt Fun	eral	Home	00001
	Н	23a. Part 1. Enter the	disease, or comp	lications that caused	the death	Do not ente	r the mode of dvir	ashingtor	or respiratory and	Idor	^†, MD.	20601 Approximate
Physician/		shock, or heart for Immediate Cause (Fin	failure. List only on	e cause on each line	e. /	1	archio	Δ		1	<u>.</u>	Interval Between Onset and Death
Medical		disease or condition resulting in death)	•	a. Due to (or as	a consequ	_	01/1/10	<u> </u>	1771	100	2,01	
Examiner	_	Sequentially list cond	litions	b. —								
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requires that the de been signed by the should be detached	/ Ph	Part II. Other significa	ant conditions co	ntributing to death b	out not resi	ulting in the ur	nderlying cause gi	ven in Part I.	23e. Did to	obacco i	use contribute to	the cause of death?
uires t n signi lld be	Completed by								1 🗆	Yes 2	□ No 3 □ Pr	obably 4 Dhknown
w requ	plete								24a. Was			opsy findings available
n: The law r icate has b r, page 2 st	mo								autop perfo	rmed?- 2 M N	death?	completion of cause of
ctor, p	Be (25. Was case referred examiner?					26. P	lace of Death (Chec		2 134.11	0] 103	2 140
Physic this or al dire	욘	1 Yes 2 X	No	-		ER/Outpatien		4 ☐ Nursing H	ome 5 Resid	dence 6	6 ☐ Other (Speci	fy)
ding F h. After funer	Certificate:		5 Pending	28a. Date of inju (Month, Da		28b. Time of injury	28c. Injur work M 1		28d. Describe h	ow injur	y occurred	
Atten	rtific	2 Accident 3 Suicide 4 Homicide	Investigation 6 Could not be determined	28e. Place of Inju	ury - At ho	me, farm, stre		Tes Z 🗆 NO	28f. Location (S	Street an	d Number or Rur	al Route Number,
tal or s afte al Dire		4 - Horniciae	determined	building, etc			,		City or Tow			a rieste Herrison,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1	Certifying Physi	ician: To the best of	my knowle	edge, death o	ccured at the time	e, date and place, a	nd due to the ca	use(s) ar	nd manner as sta	ted. ause(s) and manner stated
thin 2, the F	Me	only one) 3 L	Certifying Nurse	Practioner: To the	best of my	knowledge, d	eath occurred at th	e time, date and pla	ice, and due to th	e cause(s) and manner as	stated.
₽ .≱ ₽ 8		29b. Signature and title	e or certifier	111	/	,	29c. Licens	e number			te signed (Month	, Day, Year)
		30. Name and address	s of person who co	ompleted cause of d	eath (Item	23a) (Type Pr	rint) .	1100		2	-8-11	
BSH		Wandal	[Piar-	50n 75	035	SULLO	4+5 Pr	(0/10	iton M	M	2073	5
Stat		31. Date filed (Month, L		32. Registra		ure A	and		/11			
Registra	ir	N	MAY 12 2	UIII Dene	un	p. 19		_				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Date Month 3. Time of Death **Physician** Violet Margaret Mowen /Medical Eacility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner tagersta If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Ye Dec. 29, Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday Year) Hours 1 □ M 2 X F Months Days Min 220-16-2464 89 **Director** 1921 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Exercities must be notified at 10d. Inside City Limits Director 1 X Yes 2 ☐ No Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 133 East Sunset Avenue Funeral 21795 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married ģ If Yes, Give Year or Dates 1 ☐Yes 2√2 No Specify. 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene.
27 is marked other than 'r traumatic event, the West Elementary/Secondary (0-12) College (1-4or 5+) 6 Rivetor Aircraft Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Noah В. Gish Virgie Irene Steller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter) 133 East Sunset Ave. Williamsport, Maryland 21795 Brenda K. Braswell Pages 1 and ment of Healtt ant: If Item 27 ury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Greenlawn Memorial Park 5-16-11 | Williamsport, Maryland 4 Donation 5 ☐ Other (Specify)

Division of Vital Records, P.O. Box 68760,

the Maryland

filed within 72 hours after death with

permit. Departn Importa any inju		21. Signatural Funeral Service Lice	see		and Address of Facility Osl							
Physician /Medical Examiner		23a B44. Enter the disease, or com- shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	plications that caused the dea one cause on each line. a. Due to (or as a consec	c or respiratory arrest,	Approximate Interval Between Onset and Death							
	ilcai Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 🗌 Ectopic			23d. Date of delivery Month Day Year					
equires that ten signed b ould be deta		Part II. Other significant conditions		23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown								
: The law n cate has be page 2 sh	Сошриетеа		prior to death?	ere autopsy findings available rior to completion of cause of eath? □Yes 2 □No								
certifi ector,	De De	25. Was case referred to medical examiner?	Haenital:		26. Place of Death (Check only one)							
naing rnys ith. : After this e funeral dir	ation: 10	1 ☐ Yes 2 🕅 No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending investigation	28a. Date of Injury (Month, Day, Year)	BR/Outpatient 3 1 1 28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28c. Injury at Work? 28d. Describe how injury occurred						
tal or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, factorify)	ory, office	28f. Location (Street City or Town, St	ocation (Street and Number or Rural Route Number, ity or Town, State)					
n 24 houner Funer oletely fill	Medical	29a. Certifier (Check only one) Certifying Photostal Example 1 Certifying Photostal Example	ysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, death occurre ation and/or investigation	ed at the time, date and plac on, in my opinion, death occ	e, and due to the caus urred at the time, date	e(s) and manner a and place, and du	as stated. e to the cause(s)				
To the within the company of the com	IM	29b. Signature and title of certifier	may		9c. License number		29d. Date signed (Month, Day, Year) 5 4 12-11					
JW-1		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, Print)	1- Hagestan	4 79 0 2	1790					
State Registra	•	31. Date filed (Month Day Year)	2011 32. Registrar's Sign	ature Aar	w.		•					
MH 17 Rev 1/200)1		5.	ORIGINA	AL.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5:20 P м 2011 Gracie M. Monroe May Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Montgomery Takoma Park Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F 3/3/1919 Virginia 92 Director 227-62-6162 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at by Funeral Director 10d. Inside City Limits 28a-f s MD Prince George's Hyattsville 1 X Yes 2 ☐ No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6634 24th 20782 AVA USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.

ant. If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: African— American If Yes Give Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Domestic æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Samue1 Patrick Mattie Monroe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Green / Daughter 923 Shady Glen Dr. Capital Heights, Md 20743 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 5/14/2011 Brentwood, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fort LincolnFuneral Home Preto Mancis 3401 Bladensburg Rd Brentwood, Md 20722 23a art 1. Enter the diveare, or complications that caused the death. Do not enter the mode of dyon, such as cardiac or respiratory arrest, shock, or heart failure/ List only one cause on each line.

Immediate Cause (Fina Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a Examiner Saquer tially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 2 X No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 | Linknown Division of Vital Records, P.O. Part II. Other significant conditions contributing 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? performe Yes 2 🔀 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 X No 1 \sum Yes ပ္ 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a To the Funeral D Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature nd title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Dr. Nasreen Kango

2 2011

31. Date filed (Month, Day, Year)

Takoma Park, Md

20912

7701 Carroll Ave.

32. Registras Sign

11-03556 Wendell McClung

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death								Reg. No		
Physici	an/	1. Decedent's Name (First, Mide	dle,Last)					Date of Dea Month	ith Day	Year	3. Time of Death	
Madical Exami	ner	WENDELL		CLUNG				May 11, 2	2011	F.M.	1620 hrs	
		4a. Facility Name (if not instituti 5535 Sheriff Road	on, give street and number))		4b. City, Town, or Capitol Heig		th		County of Deat ince Georg		
F		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last	hidhday)	If Under 1 Yea		rs 8 Date of Bi		IM/DD/YYYY) 9. Birthplace (State or		
Funeral Director		577-04-0068				Months Day		in.		Forei	ign WASHINGTON	
	Usual Residence of Decedent)64	DC DC	
Any		10a. State 10b. County	,	10c. City, To	own or Locat	tion					10d. Inside City Limits	
	٦	MD PRINC	E GEORGE'S	FA	IRMOU	NT HEIGH	rs				1 X Yes 2 No	
faryland 28a-f show at once.	Director	10e. Street and Number				10f. Zip Code		1	0g. Citize	en of What Cou	untry?	
th the Maryland 23a or 28a-f sho		5535 SHERIFF	ROAD			20743	3		USA			
with ms 23	era	11. Marital Status	12. Was Decedent			as Decedent of His es, specify Cubar)- 1	4. Race - Amer White, etc.	rican Indian, Black,	
death or ite	Funeral	1 Never Married 2 N	1 Yes 2	No				to Moan, etc.)			T 4 077	
21215-0036 Muld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f she e event, the Medical E seminer must be notified at once	ò		vorced if Yes, Give Yeer or Dates:	- (-4-a) La	1	Yes 2 X No		fundi dano		Specify: BLACK . Kind of Business/Industry		
hour natu	Completed	15. Decedent's Education (Sp. Elementary/Secondary (0-12				nt's Usual Occupat nost of working life			TOD, KI	id of business	/III dust y	
336 thin 72 hae. than "nedical Edical	흴	12th	, Joseph (, . c.	,	CHE	F			PI	RIVATE		
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	JAMES WENDELL	, TAYLOR				MARTHA					
ID 21 should and Me 7 is man	P	19a. Informant's Name/Relation			19b. Mailin	g Address (Stree FOX RUN	et end Number o	Rural Route Nu	mber, City	or Town, State	e, Zip Code)	
and 2 ≥		RHONDA T. RIC	HARDSUN/SIST			FUX RUN		Date		ocation - City or		
of He Lite		1 Burial 2 Crematic	on 3 Removal from St	ate cre	matory or ot	her place)				•		
LimC Pagement		4 Donation 5 Other S		RIV		E CREMATO		/20/11	<u> </u>		MARYLAND	
Baltimore, permit. Pages 1 as Department of He. Important: If ite	21. Signature of Funeral Service Licenses/ 22. Name and Address of Facility J. B. JENKINS FUNE 7474 LANDOVER ROAD HYATTSVILLE, MAI											
Physician	\dashv	23a. Part I. Enter the disease, of	or complications that caused	the death. Do	o not enter t	474 LAND	OVER_ROA such as cardiac	AD HYATT or respiratory an	SVIL: rest, shoc	LE, MAKY k, orheart	LAND 20785 Approximate Interval	
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76(ficate ficate g phys		IF FEMALE: 23b. Was decedent pregnant in	the 23c. If yes, outcor	me of pregnar		eta! death 3 [Ectopic pregi	nancv		Date of deliver Month	ry Day Year	
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that the death certificate by the attending detached for use as	Physician	1 Yes 2 No 9 Ur	nknown g Unknown									
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Vital Regariem: The his certificate director, page	BeC	25. Was case referred to medic examiner?			_	26.Place	of Death (Chec	`				
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Division spital or Attendi hours after death. meral Director: /	Certification:	3 Suicide 6 X Cou	uld not be ermined (Specify) Re			et, factory, office b	ulluling, etc.	or Town Capitol	State) 5	535 She	riff Rd.	
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To the Ho within 24 To the Fu completel	Medical	(Check only one) 2 Medicai Ex	aminer: On the basis of exa and manner stated.	mination and/	or investiga	tion, in my opinion	, death occurred	at the time, date	and plac	e, and due to t	he cause(s)	
To con	Me	29b. Signature and title of certifi				29c. Licens	e number	,	29d. D	ate signed (Me	onth, Day, Year)	
		mel		-		O.C.I	M.E.		May	12, 2011		
0	ł	30. Name and address of perso							1			
(· · ·	ant Medical Examine			re Street, Balt	timore, MD 2	21223				
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State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 800 M المرك Shirley McKee Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Allegany Cumberland WMHS-RMC Birthplace (State or Foreign Country)
 MD Social Security Number 8. Date of Birth (Month, Day, Yo Jun 23 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 1 M 2 DF Director 217-42-6958 65 or 28a-f show 10a. State 10b. County should be filed within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Allegany MD Cresaptown 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 15101 Truly Drive 21502 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black. White, etc 1 Yes 2 No 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced white Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Tire Company billing analys Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Blanche E. (Taylor) Rotruck Walter E. Rotruck . Page 1 and 2 should Iment of Health and M tant: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **Ernest McKee** 15101 Truly Drive MD 21502 husband Cresaptown 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other Restlawn Memorial Gardens 5/24/201 Donation 5 Other (Specify) LaVale MD 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service License 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death MULTIPLE Physician, INTRACRANIAL INFARCTION disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner CTEREMIA Securitielly list conditions Examine if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and RENAI Cause (Disease or iinjury that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MFLITUS 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 XNo Other: 잍 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury Accident 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number determined e Funeral Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier in acustani 000646 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** may 7:18 AM Hamilton ouise LeMoyne 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany The Lion's Center Cumberland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 □ F Director Dec 5, 1918 217-10-5307 92 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it e Madical Exp., it in must be purified and once. MD Cumberland 1 ☐Yes 2 ☐ No Director Allegany 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21502 USA by Funeral 901 Seton Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X**lo Baltimore, Maryland 21215-0036 1 □Yes 2 □**X**io Specify Specify: 3 □ Widowed 4 □ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Nurse's Aide Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Crawford Margaret (Emmart) Crawford ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Allen MD 21532 daughter 405 Crestview Drive Frostburg 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/21/201 Restlawn Memorial Gardens MD LaVale 4 ☐ Domation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CONGESTIVE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner CURON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine the Hospital or Attending Physiclan: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □ Yes 2 **X** No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 ☐ Yes 2 No Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year)

State

Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Harit Sidhu 31. Date filed (Month, Day, Year)

26 2011

126907

925 Bishop Walsh Road, Cumberland,

State of Maryland / Department of Health and Mental Hygiene State
Registrar Aman#d#26pfh5/13/2011ccdohr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ PATRICIA ANN NEWMAN MAXY 08, 2011 10:55 PM Medical 4b. City, Town, or Location of Death WALDORF 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 9513 BROOKFIELD STREET CHARLES 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, 04-28 1 □ M **XX**F Days Hours Year 60 220-54-7431 Director 951 WASHINGTON, DC Usual Residence of Decedent 28a-f show 10a State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director CHARLES WALDORF MD 1 Tes XX No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country?
UNITED STATES Funeral 3842 GATEVIEW PLACE 20602 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2XXMarried ⋧ Yes 2**XX**Io Yes, Give Specify AFRO-AMERICAN 1 ☐ Yes XXNo Specify: "natural", Completed 3 Divorced 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) GEORGE WASHINGTON is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) UNIVERSITY HOSPITAL ENVIRONMENTAL SERVICES 12TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ BARBARA HENRIETTA TURNER NEWMAN JUNIOR THOMAS NEWMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 9513 BROOKFIELD ST., WALDORF, MD SABRINA K. WHITE /DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State MAY Pto, 1 ☐ Burial 2 ☐ Removal from State RIVERDALE" PÄRK CREMATORY RIVERDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 2011 Signatura of Europal Service Licenses of Facility TERRENCE L. JOHNSON FUNERAL SERVICE TERRENCE L. JOHNSON #M00993 4433 WHITE PLAINS LANE, WHITE PLAINS 21. Signature of Funeral Service Licensee PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Calciuma 01 disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an as 3 autopsy performed page Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? e 6 Other (Specify) Daughter's Hospital Other: 2 No 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ARes Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural Certificate: 28d. Describe how injury occurred 5 Pending injury s after death.

I Director: Af
d in by the fu Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined in 24 hour.
o the Funeral Drecompleted filler Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Within 2 To the 29b. Signature and title of certifier Do066719 30. Name and address of person who completed cause of death (Item 23a) (Type, Print). Sr #283 Waldy MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year 35AM Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death Clinton lary land rince If Under 24 Hrs 7. Age (In vrs. last birthday) If Under 1 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign Months Hours Min Snowhill **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Madical Examination 10a. State Count 10b. 10c. City, Town or Location 10d. Inside City Limits Director askind 1 Yes 2 ☐ No 10e Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral pe: DIVE 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Black Specify: 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Station Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle Maiden Surname မ 19a. Informant's Name/Relationship (Type 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) D Momas 20b. Place of Disposition (Name of cemetery, crematory or other p 1 🗆 Burial 2 🗆 Cremation 3 🌠 Removal from State -14-11 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Pridaen anham. 23a. Part 1. Enter the disease, or complications that deused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to for as a consequence of, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami the attending physician and thed for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: page 2 should be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 2 🗌 No 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Embolism Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Director: After this certificate 1 🗆 Yes 2 🗖 No Yes Hospital or Attending Physician: 24 hours after death. completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🖫 No Other မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) . Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural iniury work? 5 Pending 2 No Accident Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) tifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year) 00055120 mame and address of person who completed cause of death (Item 23a) (Type, Print) 1328 Southen auchn State Registrar

11-03451 Houshang Naderi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Cert	ificate of Death		Reg	j. No.		
Physician/ 1. Decedent's Name (First, Middle,Last)						Date of Death Month	Day Year	3. Time of Death	
Medical Exa	mine	1.003117110		NADERI			May 7, 2011 2120 hrs		
		4a. Facility Name (if not institution, give	street and number)	4b. City, Town, or L	ocation of Death	·	4c. County of Dear	th	
		University Hospital		Baltimore					
Funera		Social Security Number 6. Sex	7. Age (In yrs. las	**	If Under 24Hrs.	8. Date of Birth	(MM/DD/YYYY) 9. B	on	
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	7	Usual Residence of Decedent					, , , ,		
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Maryland		10e. Street and Number		10f. Zip Code		100	. Citizen of What Cou	intry?	
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ath v	Elizoera	1 Never Married 2 Married	Armed Forces?	If Yes, specify Cuban,			White, etc.	incarringian, black,	
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e, and and Health		20a. Method of Disposition	20b. Pla	ace of Disposition (Name of ceme	etery,	Date	20c. Location - City o	Town, State	
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tiner range	5	4 Donation 5 Other Specify: 21 Signature of Funeral Service License	12101	NEWALL ME	M·	1111	11/14/14/2	JAJ VA	
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To the How within 24 h To the Fun Completely	Medical	one) 2 Medicai Examiner:	On the basis of examination and/						
F. 2 5 8	Ž	29b. Signature and title of certifier	and manner stated.	29c. License r	number	2	9d. Date signed (Mo	nth, Day, Year)	
		WIII ()	-6.	O.C.M.	.E.	[1	May 8, 2011		
0 1		30. Name and address of person who co	moleted cause of death (Item 23	(a)					
21			ssistant Medical Examin		treet, Baltimo	re, MD 2122	3		
	State		32. Registrar's Signature			, , , , ,			
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		1- For State Registrar		ate of Death		Re	eg. No.			
Physic Medical Exam		Decedent's Name (First, Middle,Last) The DRT CE				2. Date of Dea Month	Day Year	3. Time of Death 1400 hrs		
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Funera		5. Social Security Number 6. Sex 7. Age	(In yrs. last bir				th(MM/DD/YYYY) 9. E	Birthplace (State or eign		
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imore, MD 21215 Pages 1 and 2 should be file ment of Health and Mental H tant: If item 27 is marked o or other fraumatic event, ij	일	19a. Informant's Name/Relationship (Type, Print)	19	b. Mailing Address (S				te, Zip Code)		
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Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: Hitem 27 is injury or other traumatic		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State		of Disposition (Name of ory or other place)	cemetery,	Date	20c. Location - City	or Town, State		
Baltimore, permit. Pages 1 ar Department of Hes Important: If ite		4 Donation 5 Other Specify:		stown Crem				m, Maryland		
Balt permit Depart Impor		21. Signature of Funeral Service Licensee		22. Name and Add	•		Funeral Ho			
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Division To the Hospital or Attend within 24 hours after death To the Fuoeral Director: completely filled in by the	edical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
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		Viele Vakle Ville	107	O.0	C.M.E.		May 15, 2011			
=1		30. Name and address of person who completed cause of deal Victor Weedn MD JD Assistant Medical E		900 W. Baltimore	Street Balt	imore MD 2122	3			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Yea EMMA MAE PERDUE 1313 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ioral madicul Contr If Unde If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Days Months Hours Jan. 29 1930 220-26-2012 81 Maryland Director Usual Residence of Decedent or 28a-f show 10b. County 10a. State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21804 USA 1105 Hayes Avenue 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. "natural", or à 1 Never Married 2 Married 21215-0036 Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. 1 Yes If Yes, Give 2 X No 1 ☐ Yes 2 🗓 No Specify: Specify: White Completed 3 - Widowed 4 X Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10 Presser Garment Manufacturing Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked မ John Walter Matthews Mary Emily White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .02 portant: If item 27 is rinjury or other trau Mary Patricia Cooper/Daughter 1105 Hayes Avenue, Salisbury, Maryland 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If its any injury or of 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Wicomico Mem. Park 5/14/2011 Salisbury, Maryland Zeller Funeral Home, 1212 Old Ocean City P. O. Box 3171 Road, Salisbury, . Part 1. Enter the disease, or co shock, or heart failure. List only implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ise on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): ig physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 1 Yes 2 Wo Day Month Year Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24a. Was an 24b. Were autopsy findings available has page 2 prior to completion of death? autopsy performed Yes 2 1 Yes Division of Vital eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Certificate: To Inpatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical 29a Certifier Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) 10

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05 Day 12 Terry Carl Rash 1:00 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 75 Arbor Lane Rising Sun Cecil 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Virginia Days Hours 13 M 2 | F 202-38-4338 0971571949 Director 61 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic events. — " any injury or other eve 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Director MD Cecil Rising Sun 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 75 Arbor Lane 21911 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Owner/Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Lucille (Delaney) Sabela James F. Rash Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Rash (wife) 75 Arbor Lane, Rising Sun, MD 21911 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 05/1892011 ☐ Burial 2 Cremation 3 ☐ Removal from State Foard Funeral Home, P.A. 4 ☐ Donation 5 ☐ Other (Specify) Rising Sun, MD 21. Sign we of Funeral Sovice Pensee 22. Name and Address of Facility
R.T. Foard Funeral Home,
111 S. Queen Street, Ris a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Chronic Obstructive Pulmonary disease or condition resulting in death) far 5 Medical Due to (or as a consequence of): Examiner Abuse 10 haccio Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). law requires that the death certificate be executed physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? for Day Pregnant at time of death Month Year 2 No ate has been signed by the a page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dirabetes Mellitus Type II 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown Completed MORBIO Obesit 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has | autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Vatural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 100028324

Registrar
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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.W

E. LATTIN,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jack Brantner SHOWE 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Meritus Medical Center Hagerstown Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F Days Hours Min. Dec. 6. ^{Year)}918 **Director** 214-09-4013 92 Maryland Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Washington Hagerstown 1 🗌 Yes 2 🔀 No 10e. Street and Number Loyalton Assisted Living 10f. Zip Code 10g, Citizen of What Country? Funeral 20009 Rosebank Way 21742 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: white 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. 16b. Kind of Business Industry (Specify only highest grade completed) United Pipefitter Elementary/Seconday (0-12) College (1-4 or 5+) pipefitter 12 Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Frisby Brantner Showe Mary Josephine Strode 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2218 Savanna Way, Palm Springs, CA 92262 Barry Showe - son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Rest Haven Cemetery 5/13/11 Hagerstown, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licens 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due id (or as a cons quence of) attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed mention resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Year the 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. þ 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an his certificate has to director, page 2 s performed?

1 Yes 2 No death? Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: ျု 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred eral Director; After filled in by the funer Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide To the Hospital 24 hours Medical 29a. Certifier Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29c. License number 02 Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 08 201 Physician/ Month 2:45 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death West NED~ Mep, tus OPUS. DROSSIGNI Social Security Number . Sex 1 🛣 M 2 □ F 7. Age (In vrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign Months Min Country)
Indiana **Director** <u>319-52-6094</u> 54 1957 f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f Maryland Washington Hagerstown 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 68 West Side Avenue 21740 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. þ 1 Never Married 2 X Married should be filed within 72 hours after and Mental Hygiene. is marked other than "natural", or Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: Year or Dates any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Software Developer Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Shelby Smith Frances Haderly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is Michael Smith - Son 68 West Side Avenue, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🖾 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Hagerstown Crematory 5/11/2011 Hagerstown, Maryland . Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home .5 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death asustole Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) We to B. Werd vesterd OBSTANTEN Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death signed by the aid P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of DNEUMON 24a. Was an has autopsy perforn death? this certificate 1 Tes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medica To Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural N 5 Pending injury work? 1 ☐ Yes 2 🗌 No Accident Investigation Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Turse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ceptifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #17 Per FH G916 6/08/2011 JH
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 5 Physician/ Month Year te war 1840 arry James May 2011 Medical 4a. Facility Name (if no institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death HOSPITAL TAIboT emorial EASTON 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months Hours (Month, **Director** Marylano Usual Residence of Decedent shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director injury or other traumatic event, the Medical Examiner must be notified. $\underline{\bf e}_{\rm s}$ 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 2160 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Ves 2 No 1970 Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important, If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examina once. 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Black Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) uto-Boo etailer Be Maryland 17. Father's Name (First, Middle, Last) Steward Sr. 18. Mother's Name (First, Middle, Maiden Surname) A. မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R ral Route Number, City or Town, State, Zip Code) 53/12 St. hilade rea Jones Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
M. d Shore (YeMation Cha 1 Burial 2 Cremation 3 Removal from State 13/11 4 ☐ Donation 5 ☐ Other (Specify) Colleen Curran Branwell RA 22. Name and Address of Facility
Henry Funeral Home, 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD.21613 Approximate Interval Between Respiration Immediate Cause (Final Onset and Death Ph sician/ Acute tailure disease or condition Medical resulting in death) 04-24-2011 Examiner Dreumon Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner as a consequence of) 05-05-2011 Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year been signed by the a should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Exacerbation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Aroxic Encephalopathy Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate he completed filled in by the funeral director, page Cardiac arres 2 🗌 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No ျှ 1 Inpatient 2 [ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 \square Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. tle of certifie 2 29b. Signature ar MD 05/06/2011 D00694 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KalakurThi Easton Memorial Hospital Samantha 31. Date filed (Month, Day, State 13 Registrar

STewa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 6:02 P M ZABETH SEAMAI Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death JIDN If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) vrs. last birthday) 8. Date of Birth **Funeral** 212-10-6888 Months Hours Director Usual Residence of Decedent 10a. State Ħ Town or Location with the Maryland 10d. Inside City Limits Director r 28a-f s notified PAROLINE RESTON 1 ☐ Yes 2 ☑ No 10e. Street and Number ms 23a or must be n ö 10f. Zip Code 10g. Citizen of What Country? Funeral items 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 5 þ 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No 3 ₩idowed 4 Divorced WHITE "natural", Completed of Health and Mental Hygiene. item 27 is marked other than "natul other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMIAMAK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ WILSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, t of Health a 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 9 1 Burial 2 Cremation 3 Removal from State Department Important: If any injury or once. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ INSUFFICENCY disease or condition resulting in death) UTE CORDWARY Medical Examiner ROMIC TREBUISCUETETIC Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy☐ Pregnant at time of death 5 ☐ Other (specify) in the past 12 months 1 Yes 2 No Day Month Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? certificate 2 🗌 No 1 Yes 2 No Division of Vital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director. After this completed filled in by the funeral dir 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred Hatural Accident 5 Pending 28e. Place of Fury - At home, farm, street, factory, office building, etc. (Specify) 1 ☐ Yes 2 XNo Fell While Attempting to Stand
281. Location (Street and Number or Rural Route Number)
City or Jown. State) Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide determined CNH, 520 Kmr Ave, Denten 21629 HOME Hospital Medical pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as statted. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00053255

DHMH 17 Rev 7/2009

State Registrar Cause of Jeath Item 23a) (Type, Print)

3683

DOOL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ <u>10:30 ^A ⋈</u> MAY 2011 HELEN SAUNDERS Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** CENTREVILLE QUEEN ANNE'S CORSICA HILLS NURSING HOME If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign ecurity Number 7. Age (In yrs. last birthday **Funeral** 1 🗆 M 2 🗶 Months Days JAN. 6. SOUTH CAROLINA Hours Min. 1930 Director 249-40-6314 81 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County Director 1 Yes 2 X No MARYLAND CAROLINE RIDGELY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral UNITED STATES 21660 19 ROBINS COURT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after death 14. Race - American Indian, Was Decedent Ever in U.S. 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. Ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: BLACK 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) NURSE HEALTH CARE Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) CARRIE LEE WILLIAMS UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19 ROBINS COURT, RIDGELY, MARYLAND 21660 JOSEPH BELLARD/GRANDSON 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition CHESAPEAKEOOCKEMATION CENTER MAY 8 2011 1 Burial 2 X Cremation 3 Removal from State STEVENSVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME P.A. 408 SOUTH LIBERTY STREET, CENTREVILLE, MD 21617 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Prath Immediate Cause (Final ₽hysician/ disease or condition resulting in death) Medical Examiner rears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami ears that the death certificate be executed that initiated events for as a consequence of resulting in death) Last burialattending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 12 months? 3 Ectopic pregnancy in the past 14 Month 5 Other (specify) the 9 Unknown P.O. I ed by t detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed be should be deta 23e. Did tobacco use contribute to the cause of death? þ 4XI Unknown 1 Yes 2 No 3 Probably Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Jas page 2 Hospital or Attending Physician: The 2 No certificate ☐ Yes Yes 26. Place of Death (Check only one) 25. Was case referred to medical Division of Vital director, Be examiner? Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Natural After injury 5 Pending 1 Yes 2 No M Accident Suicide Investigation within 24 hours after death To the Funeral Director, completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar e of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mary H. Townsend. 8:20 P **201**1 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Berlin Nursing And Rehabilitation Center Worcester 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. If Under 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) 01/11/1922 89 Months Days Hours Country) Horntown Director 230-14-1875 Usual Residence of Decedent show 10a. State 10b County the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes 2 No VA Accomack Horntown ō 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be with 1 Funeral items 23a 4420 Fleming Rd. 23395 USA death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates 2 X No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. "natural" Completed 3 Wildowed 4 Divorced Specify. Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) during most of working (Give kind of work done life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) filed within and Mental Hygiene. Is marked other tha the Outreach Worker Medical Center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be ment of Health and Menta Julius Hope Hallie Justis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trau Arnold Downing / Grandson 11 Franklin Square, , Berlin, MD. 28111 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State injury or 1 Burial 2 Cremation 3 Removal from State Dea's Chapel Cemetery 5/14/2011 Horntown, VA Donation 5 Q Other Signature of Fun 22. Name and Address of Facility Cooper & Humbles Funeral Co., Inc., Accomac, VA 23301 Part 1. Enter the disease, or co shock, or heart failure. List only his that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final [°]Physician/ their disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Physician: The law requires that the death certificate be executed burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last been signed by the attending physician should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Dav Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 XJnknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an has After this certificate 2 **X** No 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 🗶 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 XNursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 27. Manner of Death 1 XNatural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 5 \square Pending iniury 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) R 135131 May 9, 2011

BA 3 State

Townsend,

Registrar

9715 Healthway Dr, Berlin,

MD

21811

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

32

egistrar's Signature

Savage,

Pennie

31. Date filed (Month, Da

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 612 Month Day Year MAY 2:56 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 30 CARVER STREET ANNE ARUNDEL <u>ANNAPOLIS</u> 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 03/11/1934 **Funeral** If Under 24 Hrs. 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Days Hours Min. Months **Director** 27-38-8612 VIRGINIA Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 30 CARVER STREET 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Black, White, etc. ò 1 Never Married 2 Married Completed by Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: 3 XWidowed 4 ☐ Divorced "natural" Specify BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 CARPENTER CARPENTRY other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of မှ permit. Page 1 and 2 should be Department of Health and Menta Important; If item 27 is marked any injury or other GEORGE E. TAYLOR DELLA SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHARON TAYLOR/DAUGHTER 30 CARVER STREET. ANNAPOLIS. MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State BESTGATE MEMORIAL 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/14/2011 Signature of Euneral Service Licer 22. Name and Address of Facility HELFENBEINESTRE P.A. 814 BESTGA sant 1. Enter the disease, of shock, or heart failure. List or complications that caused the death. Do not enter the mode of dying, stonly one cause on each line. Approximate Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ retail COLD
☐ Pregnant at time of death
☐ Unknown Ectopic pregnancy 3 ☐ Ectopic pregrie
5 ☐ Other (specify) signed by the atte in the past 12 months? Day 2 No Yes Unknown Part II. Other significant conditions contributing ting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 Yes 2 No 3 Probably 4 Nhknown Completed peen Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform ASTRO infesting 20 2 No 1 🗌 Yes Yes funeral director, 25. Was se referred to medical æ 26. Place of Death (Check only one) examiner? 2 No Certificate: To 1 Inpatient 2 I ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗆 No filled in by the Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours or To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and time 29d. Date signed (Month, Day, Year) W ause of death (Item 23a) (Type, 30. Name and

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2326P M Della Shorter Tyler 2011 Mag 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Dordester General HESPITAL Cambridge Dorchaste 5. Social Security Number f Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday Date of Birth (Month, Day, **Funeral** Year) Months Days Hours Min 1 □ M 2 😿 F Director 216-18-8514 85 14, 1925 Maryland Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits ed other than "natural", or Items 23a or 28a-f sho event, I'm Modest Eventing mast be notified at MD **Funeral Director** Dorchester Cambridge 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 911 Roslyn Avenue 21613 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. sem 27 Is marked other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2X ☐ No Specify. Completed by 3 → Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker 11 own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles E. Shorter Hilda Mae Marshall ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Chris Tyler 911 Roslyn Avenue, Cambridge, MD 21613 son Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem. 4 ☐ Donation 5 ☐ Other (Specify) 5/16/11 Hurlock, MD 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 - Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) P.O. signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 12 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s After this certificate has autopsy perform 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of dertifie 29d. Date signed (Month, Day, Year) erson who completed cause of death (Item 23a) (Type, Print) Name and address of D; 0 31. Date filed (Month, Day, Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 14 Day Physician 2011 May 10:15 AM Shirley Anne Thomas /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Ridgely Caroline 11621 Eveland Road 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Maryland Days Hours 1 □ M 2 💢 F September 6, 1937 Director 214-34-8591 73 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If we Purical Examinating the natitied at 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Directo Caroline Ridgely Maryland | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11621 Eveland Road 21660 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 📉 No Specify. Completed by Specify: 3 ☐ Widowed 4 💆 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lineworker Cannery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helen Louise Pinkney James Lewis Morgan ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Polly Mason/daughter 4455 Laure Grove Road Federalsburg, Maryland 21632 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State May 21, 2011 Hillsboro, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Sandtown Cemetery 21. Signatur of uneral Serv 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street Denton, Maryland 21629 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2121 **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Electrically in Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and and burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physiciar Physician/Medical as the use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death 1 □Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 □ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 05/132 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21601 Jorge Abrego, M.D. 598 Cynwood Drive Easton, Maryland 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 5 2011 VOYLES 1259 PM VIRGINIA LEE Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Salisbun Regional modical cente WICOMICO 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🗶 F Months Hours Min. 9/15/1932 78 231-46-9746 Maryland Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location at 10d, Inside City Limits Director r 28a-f st notified DE Sussex Delmar 1 Yes 2 No 10e. Street and Number 10f. Zip Code ms 23a or must be r ö 10g. Citizen of What Country? Funeral TISA 19940 12 Golden Lane items 2 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. "natural", or item ledical Examiner r 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 homemaker homemaking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Sadie Gibson Harry Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8034 New Hope Road, Willards, MD 21874 Mary Ann V. Furches/ daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State 5/25/2011 Belle Haven Cemetery Belle Haven, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer rvice License 22. Name and Address of Facility P.O. Box 633 Doughty Funeral Home Exmore, VA 23350 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ischemi Physician, disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner MUNHO Mir-1 Jever Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Leans To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Aria Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a Part II. Other significant Conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Read Vanhung 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Sua Sini Synon 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Arrest Carbai 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: ဂ ER/Outpatient 3 DOA 1 Inpatient 2 ... funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of Natural 28c. Injury at 28d. Describe how injury occurred 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D44663 5. 22 2011

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY 7, 2011 GAIL ALICE VANEMAN 5:05 \mathbf{P} M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death HOSPICE CENTER CENTREVILLE QUEEN ANNE'S Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days NOV. 13, Year 1945 1 M 2 X 136-38-1732 NEWY JERSEY **Director** Vrs 65 Usual Residence of Decedent show or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND QUEEN ANNE'S 1 Yes 2 XNo **OUEENSTOWN** 10e, Street and Number ō 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 112 THOMPSON AVENUE 21658 UNITED STATES 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify WHITE 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) STATE OF NEW JERSEY SOCIAL WORKER other other traumatic event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o ၉ WILLIAM WHITEHEAD **EVELYN MCCARTHY** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, KENNETH H. VANEMAN/ HUSBAND 112 THOMPSON AVENUE, QUEENSTOWN, MARYLAND, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of CHESAPEAKE) Important: If it any injury or o MAY Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) CENTER 2011 STEVENSVILLE, MARYLAND 21. Signature of Funeral Service Licensee FELDOWSANDHEARENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND, 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter or userying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami tran Due to (or as a consequence of) resulting in death) Last burial physician s the burial Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 nding parse as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital HOSPICE CENTER 2 No Other: 1 Tyes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury after death. 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number __ Homicide determined City or Town, State) 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my know occurred at the time, date and place, and due to the cause(s) and manner as stated within 7 29d. Date signed (Month. Dav. Year)

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who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician /Medical 11:49 AM 201 ODCY 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, You Sep • 21, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 1963 Mary Land **Funeral** 47 219-94-1001 **Director** Usual Residence of Decedent e filed within 72 hours after death with the Manyland al Hygiene. other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at 1 ☐ Yes 2X No Maryland Anne Arundel Annapolis Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code U.S.A. 21401 2608 Greenbriar Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo White Specify: 2 3 Widowed 4 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Project Supervisor Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fill ment of Health and Mental Hisant: If item 27 is marked ott Cassandra Ebersole Wantz Robert A. Wantz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13320 Fairfax Rd. Hagerstown, MD 21742 Robert A. Wantz-father 20a. Method of Disposition
1 XBurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or or Rest Haven Cemetery 5-17-2011 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final bleeding Massive internal Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** chorio carcinoma Metastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and a for use as the burial-tranresulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? Was an autopsy performed? 24a. Was an certificate has 1 Yes 2 No 1 Yes the Hospital or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check onl one) Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No ER/Outpatient 3 DOA မ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred completely filled in by the funeral Certification: s after death. Injury 1 Natural 5 Pending investigation 1 Tes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier KES-000 5-11-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) He 600 North Wolfe St, Baltimore, MD, 21287 gistrar's Signature 31. Date filed (Mon State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year James Horatio Willey 3:07 PM Medical 20 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death omica 6. Sex 1 □ M M 2 □ F 8. Date of Birth If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Months July Ply, Year 947 ^cMaryland 216-64-8430 63 **Director** Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD Dorchester Hurlock 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 117 Thompson Street 21643 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Black, White, etc. 0 þ 1 X Never Married 2 Married 1 ☐ Yes 2 K No Specify. white "natural" Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore, Maryland 212 disabled did not work Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve any injury or other traumatic evegines. မ Julian Homer Willey Peggy Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew E. Willey brother 2455 Andrews Road, Crapo, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ■ Burial 2 □ Cremation 3 □ Removal from State East New Market Cem. 4 ☐ Donation 5 ☐ Other (Specify) 5/16/11 East New Market, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 16. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death ARCINOWA **Enysician** Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy Ö in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2 No the be detached g 🗌 Unknown g Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown Completed 1 Yes 2 No To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 24a. Was an autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No PICTE မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Matural Natural iniury 5 Pending 1 Yes Accident Suicide Investigation 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 h (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated CFT Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) and fitle of certifier 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 Hunter 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 1 Pay 1:09 p M 2011 Daniel Lee Woolford Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3404 Beaver Neck Road Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. . Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign Funeral ^{Year}1951 April 8 1 X M 2 D F Maryland 215-58-5153 Director 60 Usual Residence of Decedent 10a. State items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Dorchester Cambridge 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3404 Beaver Neck Road 21613 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. Yes 2 X No ģ 1 Never Married 2 Married "natural", or Maryland 21215-0036 1 Yes 2 X No Specify white Specify: 3 Widowed 4 X Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) freight truck driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roland Copeland Woolford Bertha Mowbray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Danielle Woolford-Badur daughter 834 Bloomfield Dr., Harrington, DE 19952 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 D Burial 2 👿 Cremation 3 D Removal from State Crematory of Delmarva 5/12/11 Delmar, DE 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Coronary Vagaclar Physician orterioscherofic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): sician and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 1 Yes 2 No signed by the a g 🔲 Unknown Division of Vital Records, P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate | Yes 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 040120 (Item 23a) (Type, Print) Anderby Hull Rd, Royal Oak Md 21662 5500 State Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		FiedS	State of Marylar	nd / Dep	artmen	t of Health	and N	-		•	10010	
Physicia	2/	Registrar 1. Decedent's Name (First, Middle, Last)			runcate	tificate of Death			th Day		3. Time of Death	
Medic	al	THOMAS MILTON W			т	APRI						
Examin	er	4a. Facility Name (if not institution, give street and number) 925 MONROE MANOR ROAD				4b. City, Town, or Location of Death STEVENSVILLE			4c. County of Death			
Funeral		Social Security Number 6.	If Under Months		er 24 Hrs.	8. Date of Birth	Year)	9, Birth	nplace (State or Foreign			
Director		219-07-3248 Usual Residence of Decedent	Sex. 1 Am 2 ☐ F 7. Age (In yrs. 90	Yrs.				SEPT. 1	2,	1920 MÃ	RYLAND	
land f show d at	iç	10a. State 10b. County	10c. Ci	ity, Town or Lo	ocation		-				10d. Inside City Limits	
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eath v	Funeral	925 MONROE MANO 11. Marital Status	12. Was Decedent Ever in U.	.S. 13.	Was Deced	21666 ent of Hispanic C	Origin? (Spe	ecify Yes or No-	$\overline{}$	14. Race - Ameri		
ifter d ", or i	δ	1 Never Married 2 Married	Armed Forces? 1 X Yes 2 □ No If Yes, Give			fy Cuban, Mexic		Rican, etc.)		Black, White Specify: WHI'		
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ould bind Mel	`	RAYMOND NORMAN 19a, Informant's Name/Relationship		10b Maili	na Address			TT KNIG		Town State 7in	Code	
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of Her of Her fitem		20a. Method of Disposition 1 Burial 2 Cremation 3	20b.	Place of Dispo	osition (Nam	e of		Date		ocation - City or T		
Page ment tant: I		4 Donation 5 Other (Spe		ESAPEAN CENT	CE CRE	MATION	MAY 2011	4	STEV	ENSVILL	E, MARYLAND	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice	nsee A	2	Z. Name and	Address of Fac	ENBEI	N & NEW	MAM	FUNERAL	HOME P.A.	
		23a. Part 1. Enter the disease, or co	mplications that caused the dea	1 1	00 SH	AMKUUK K	CUAD,	CHESTER	, M/	AKYLAND	21019	
Physician/		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.								Interval Between Onset and Death	
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Certificate:	4 Homicide determine			reet, factory	office		28f. Location (Si City or Town			al Route Number,	
ospital hours ineral d filled	Medical		nysician: To the best of my know									
the Ho nin 24 the Fu	Med	only one) 3 Certifying Nu	miner: On the basis of examination urse Practioner: To the best of m					e, and due to the	cause(s) and manner as s	stated.	
		29b. Signature and title of certifier	meoreal a	d 14. 2.		License number			29d. Dat	e signed (Month,	Day, Year)	
5		30. Name and address of berson who	MEDICAL ON			000	070	2 d	7	~ Ny	03/04/1	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** May 9: 32PM 2011 William Strauss Aiken, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hospital Agnes Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Year) Months Days Hours 1 X M 2 ☐ F 90 158-09-9417 1920 Nov 11, New Jersey Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director MD Bowie Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2918 20715 U.S.A. Blueberry Lane by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NASA Aeronautical Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Strauss Aiken. Sr. Amy ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Reisterstown, Maryland 21136 233 Glyndon Drive Frances Mitchell Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 5/31/11 Hampstead, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Stephen entins ELINE FUNERAL HOME 21136 Reisterstown, MD Approximate Interval Between Onset and Death 23a. Part 1. Enforthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Se PSIN Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Day 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. **∆** 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 □Yes 3 □No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1☐ffipatient 2☐ER/Outpatient 3☐DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred U☐Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, 1:0. Box 68760, To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di

Funeral

Director

28a-f show

r than "natural", or items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, Item Importants or other traumatic event, Item Importants or other traumatic event.

Physician

/Medical

Examiner

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certificate

DHMH 17 Rev 1/2001

director.

Baltimore, Maryland 21215-0036

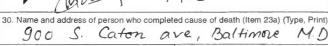
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diken, William

31. Date filed (Month, Day, Year) State Registrar

900

29b. Signature and title of certifie



and manner stated.

Registrar's Signature

29c. License number

21229

P25485

29d. Date signed (Month, Day, Year)

27

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician MARO 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1+AR 8. Date of Birth (Month, Day, 6. Sex Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Months Days Min. 8_ 1 M 2 □ F Hours Yrs. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, Ite Medical Examinar must be notified at Director 1 Yes 2 No RYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 0 05 Funeral ON 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. 1 Never Married 2 Married than "natural", or Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑ No þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Hygiene. College (1-4or 5+) permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other trainmant. ction LOUNSIER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Ted 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 706 Ponderosa >n ARON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lices ChorNACKI Fundrol ITIMORE. 23a. Part 1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year signed by the a 5 Other (specify) Part II. Other, significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed . Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No has page 2 autopsy performed' certificate 1 □ Yes 2 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∭Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No after death Director: within 24 hours after des To the Funeral Director completely filled in by th 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Propertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State

DHMH 17 Rev 1/2001

Vital

Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type

29c. License numbe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0539 ernard Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore University of Maryland Medical Cente: 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 □ F (Month, Day, Year) 9-10-1927 29-28-5866 Month Country) V **Director** Usual Residence of Decedent items 23a or 28a-f show er must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No Himore 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code Funeral E. event, the Medical Examiner must 1400 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married and Mental Hygiene. is marked other than "natural", or i Completed by 1 Yes 2 No Maryland 21215-0036 Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Segonday (0-12) College (1-4 or 5+) eaborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Boo other traumatic permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Orraine Baltimore, 20a. Method of Disposition 266. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State any injury or 4 ☐ Donation 5 ☐ Other (Specify) Farmville. 22. Name and Address of Facility March F/H 1101 E. No th 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Immediate Cause (Final Onset and Death ₽nysician/ Due to Has a consequence of) disease or condition resulting in death) Year5 Medical Examiner Myocardial Sequentially list conditions, Examine if any leading to immediate cause. Enter Underlying Dule to for each consciousness of Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte Month Dav Year 5 Other (specify) Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been siç , page 2 should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2 a autopsy performed 1 ☐ Yes 2 ☑ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death. **To the Funeral Director:** Ai completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month. Dav. Year) AU41764355100626 26 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 5 Greene 54 Baltimore MO 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3:00 PM 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOSPITA(IMC If Under 1 Year If Under 24 Hrs. Social Security Number Funeral 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 XM 2 □ F Days Hours Min. Director 78 252-48-7529 GA /25/193 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore 1X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2861 Seamon Ave. 21225 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Black 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Athens Cleaners Spotter 6th N/A other traumatic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Eunice Mill Thomas Burley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carrie E. Burley- Daughter 2861 Seamon Ave. Baltimore, MD 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemt. 6/2/2011 Baltimore, MD 21. Signature of Euneral Service Licensee 22. Name and Address of Facility March F/H 1101 E. North n Melken Balto., MD 21202 Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death IERE Physician/ Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, coordinated and course. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit that the death certificate be executed Exam resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Pregnant at time of death Month Day Year 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 124 hours after death.
24 hours after death.
Preneral Director: After this certificate has been sign eted filled in by the funeral director, page 2 should be eted filled in by the funeral director, page 2 should be HYPERTENSION ATRIAL FIBRILLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🔀 No Hospital Other: မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending Accident
Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEL MAVER HANO 37 State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2^{Day} 2°0 1 1 William W. Baines, Jr. 3:30 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 9401 Wordsworth Way Unit#104 Owings Mills Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1**X**XM 2 □ F (Month, Day, Months Davs Hours Min New York Director 88 1922 077-18-1242 Nov. Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo MD Baltimore Owings Mills 10e. Street and Numbe 10g. Citizen of What Country? Funeral 9401 Wordsworth Way Unit# 104 21117 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Armed Forces?

1XXYes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 XX Married \$ 72 hours after Maryland 21215-0036 "natural", 1 Yes 2XXVo Specify. 3 Divorced White Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 I h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 4 Sales Rep Business Supply Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, William W. Baines, Sr. Marie Josephine Dunne I and 2 should b f Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23602 Conerstone Ln. Damascus, MD 20872 Matthew Baines / permit. Page 1 and 2 Department of Healti Important: If item 2 any injury or other 1 or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery crematory or other place)
All Faiths
Crematory & Chap 1 Burial 2 X X remation 3 Removal from State 4 Donation 5 Other (Specify) 5/31/11 Manchester, MD Chape1 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 21. Signature of Fund 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ years Medical resulting in death) Examiner Sequentially list conditions, if any cause. Enter Underlying Examine Due to jor as a consequence of or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ctopic pregna Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death the should be detached þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 2 ZNo 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform 1 Yes 2 No Yes director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 1 Tyes 2 🕏 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 잍 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: A Accident Investigation 6 Could not be Suicide in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the pasis of examination allows investigation, in my opinion, sealing action and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 03757 of death (Item 23a) (Type, Print) 30. Name and address of person who comple 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 25, per phy, g915 5-31-11 sm
State of Maryland Department of Health and Mental Hygiene
Amend Item 26 per dr., g916,06/03/2011dhb
Certificate of Death

Reg. No. 1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav Year Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bi Me 8. Date of Birth (Month, Day, Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** M 2 □ F Days Hours 5 Director 213-70-3787 Usual Residence of Deceden 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 ☐ No MD Anne Arundel Pasadena 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 4505 A Mountain Road 21122 items death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married þ 72 hours after Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Specify: "natural" White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Powell & Turner Elementary/Seconday (0-12) College (1-4 or 5+) 12 HVAC Technician Heating & Cooling 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Allen Eugene Fritz Norma J. Burkhart Fritz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma J. Fritz - Mother Loalan Ave., Dundalk, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2X Cremation 3 ☐ Removal from State Atlantic Crematory 5-25-11 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral Home
DA 2134 Willow Spring Road, 21222 21. Sign 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause 1 each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine as a consequence of and -transit resulting in death) Last burialattending physician for use as the buria Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No g Unknown g Unknown detach Part II. Other significant conditions contributing to death but not resulting n the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be det þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an or Attending Physician: The law has autopsy erforme death? 1 Yes 2 No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 1 Inpatient 2 မ ER/Outpatient 3 DOA the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completed filled in by the funeral Natural work? 5 Pending 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cortifier BC 30. Name and address of person who completed Highway, Golen BurNIE, MS, Suik 502, 21061 Sang 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mayth 27 ay 2011 9:56 A M Louella Marie Bourckel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Parkville 8002 Manor Road If Under 1 Year If Under 24 Hrs. Funeral . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign March 27, 1915 1 M 2X F Days Hours West Wirginia 96 219-03-8078 Director Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Baltimore Baltimore Maryland 1 Yes 2X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4300 Cardwell Avenue 21236 Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 White Yes, Give 1 ☐ Yes 2 X No Specify. "natural", 3 Widowed 4 ☐ Divorced Specify: Completed Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) nt of Health and Mental Hygiene.
It itiem 27 is marked other that or other traumatic event, the N 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jessie Freeland Artie Fearer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2516 Gladstone Court Bel Air Maryland 21015 David Bourckel/Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Service Corp. 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Department of Important: If any injury or 6/1/11 Towson Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck 5305 Harford Road Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final CARDIOPULMONARY ARREST Physician/ disease or condition Medical resulting in death) **Examiner** 'ERSCLEROTIC duentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death the detached 9 Unknown 9 Unknown signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FIBRILLATION 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) Son & Sidence 2 W No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Cate of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

State Registrar

DHMH 17 Rev 7/2009

29b. Signature and title of certifier

asmin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0061480

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician PM 4a. Facility Name (If not institution, give street and number) 5:14 1117 33 2011 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 **X** M 2 □ F Yrs. 216-34-1237 **Director** Maryland Feb. 1. 1939 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10h. County 10d. Inside City Limits 28a-f show Examiner must be notifled at 1 ☐ Yes 2 🛛 No Directo Maryland Baltimore Dunda1k 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be n Funeral 7003 Dunmanway United States
14. Race - American Indian,
Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2♥ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 Widowed 4 Divorced White Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 8 years Convenience Store Manager 7/11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Bouthner Anna Genco 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Bouthner (Wife) 7003 Dunmanway Apt. B Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Service Corp. 5/27/2011 22. Name and Address of Facility Towson, Maryland Funeral Sowice Accepted 21. Signatur any in once. Duda-Ruck Funeral Home of Dundalk, Inc. leath. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approx 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY **Physician** 32 pours disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 33 here NEMMBUIL Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of, The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) burial Box 68760, attending physician Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ŏ in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 2 🗌 No ed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, pe 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy has performed? 1 Yes 2 No certificate Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Inpatient 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ၉ this in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: or Attending After Injury Natural 5 Pending investigation s after death. 1 🗌 Yes 2 🗌 No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) determined 4 Homicide the Hospital 24 hours a filled 29a. Certifier (check only Scritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

PANACK 20TA 31. Date filed (Month,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RE9-008

37

4940 Eastern Avenue, Baltimore, MD, 21224

1100

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ may *aeaskey* 1145A ZOII Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death Randallstown Examiner 4c. County of Death Seasons Hospice Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days Hours Min. Months 1 □ M 2 X 219-32-2839 0372971936 Country) Director PA Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Baltimore Baltimore X ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
USA Completed by Funeral 21215 2863 West Garrison Ave death 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 Yes 2 No Black White etc 1 Never Married 2 Married altimore, Maryland 21215-0036 and 2 should be filed within 72 hours after Black 1 Yes 2 No Specify. If Yes, Give 3X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Care Provider Medical Home Health Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Enda Thomas ပ Unavailable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) r 3808 Pinkney Rd Baltimore 21215 Department of Health ar Important: If item 27 is any injury or other trau Carendy Candy Smith Daughter 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 Atlantic Crem 05/28/11 Glen Burnie MD 4 Donation 5 Other (Specify) of Funeral Service License 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllen PA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months 1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year been signed by the sahould be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 has performed or Attending Physician: The this certificate 1 Yes Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 21 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify 27. Manne Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After it completed filled in by the funera Natural 5 Pending 2 🗌 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 11 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier of death (Item 23a) (Type, Print) DACID mi 21209 Smith 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Brown 0:40 AM oria 05 Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours April Day New York T929 084-24-7438-A 82 Director Usual Residence of Decedent r 28a-f show notified at 10c, City, Town or Location 10d. Inside City Limits 10a State 10b. County death with the Maryland Director Md. Glen Burnie Anne Arundel 1 Yes 2 No 10f. Zip Code ō 10e. Street and Number 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 7466 E. Furnace Branch Rd. Apt. 302 21060 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 Yes 2XXNo
If Yes, Give
Year or Dates. Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify: Specify:White "natural", Completed 3 X Widowed 4 Divorced Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natu ury or other traumatic event, the Medical. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Walter John Yaggie Martha Washington Beck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha A. Brown/Daughter 5111 Circle Place Halethorpe Md. 21227 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State Department of Important: If any injury or once. Bayview Crematory 5/21/2011 Balto. Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service P.A. Signature of Funeral Service Licensee monce Ritchie Hwy. Balto. Md. 21225 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, Interval Between shock or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to for as a consequence of Examir Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Cause (Disease or iiniury and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Year Day Pregnant at time of death 5 Other (specify) the detached Unknown 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy this certificate has 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital: Other: 2 No 1 Tyes ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 Inpatient 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work?
1 ☐ Yes 2 ☐ No 5 Pending s after death.

I Director: Af Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0056046 30. Name and address of person who completed cause of death (Item 230) (Type, Print)

Potticia Gao 203 Hospital Drive Suite 210, Glen Burnie, MD2 1061

Registrar DHMH 17 Rev 7/2009

State

Gao

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc g915 5-31-11 yt. State of Maryland 7 Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Ralph 2. Date of Death Jay Baron Physician/ 6:461 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SUNRISE ASSISTED LIVING PIKESVILLE BALTIMORE 5. Social Security Number Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months 218-32-5542 75 02/25/1936 Country) **Director** Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director BALTIMORE MD BALTIMORE 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3800 OLD COURT ROAD, #104 21208 USA death v 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify WHITE If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the MAIL CLERK SOCIAL SECURITY Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic even 2 FRANK BARON GERTRUDE NIDITCH 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AMY MARKOWITZ / NIECE 4 DEER STREAM COURT OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
BETH ISAAC ADATH
ISRAEI 1 X Burial 2 Cremation 3 Removal from State 05/26/2011 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Man Co 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition CENCIA C MINLLE Medical resulting in death) Due to (or as a consequence of) Examiner eurs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last the attending physician Physician/Medical lear requires that the death certificate be Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No ò Pregnant at time of death 5 Other (specify) Month Year 1 Yes 2 9 Unknown Day 4 Pregnant 9 Unknown been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a, Was an Hospital or Attending Physician: The law page 2 s has prior to completion of cause of death? performed? certificate 2 🗆 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospita! 2 No 1 Tes ည 1 Inpatient 2 ER/Outpatient 3 DOA After this Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending (Month, Day, Year) injury M 1 Yes 2 No 24 hours after death Accident Investigation the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) HMalnu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5. H. MALINOW 2700 (Læke 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death MAY 21, 2011 Physician/ 12:05р м **JAMES** THOMAS BENZING Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE 3217 FOSTER AVENUE 8. Date of Birth NOV 13, 1928 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 🔀 M 2 🗆 F Months Hours MARYLAND 220-20-1943 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County Director BALTIMORE 1 X Yes 2 No MD N/A10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral U.S.A. 21224 FOSTER AVENUE 3217 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: WHITE Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) PIPEFITTER BETHLEHEM STEEL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ ELIZABETH DORN GEORGE BENZING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 524 STRATFORD RD., FALLSTON, MARYLAND 21047 BARBARA SMITH/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1

M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) JESUS 5/25/11 BALTIMORE, MARYLAND SACRED HEART OF Signature of Functional Service Licenses ™ŽËTTER INC. FUNERAL HOME CONKLING STREET,BALTO.,MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of doing, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ OCA Medical resulting in death) Due to (of as a consequence of Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending physion of the back IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months? Pregnant at time of death Yes 2 No signed by the a d be detached f g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ After this 27. Manner of Deal 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 5 Pending 1 Yes 2 No death. Accident
Suicide Investigation neral Director; A 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D

completed filled i Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signat**¢** 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2801 HUDSON ST BALTO ONAL Registra

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** pabrina a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 15, 1 7. Age (In vrs. last birthday 5. Social Security Number Days **Funeral** New Mexico 31 585-65-4609 **Director** Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a State 10h County 28a-f show Examiner must be notified at 1 Yes 2 X No Director Laurel MD Howard 10g. Citizen of What Country? 10e. Street and Number 10f Zin-Code ò U.S.A. 20723 or items 23a 8401 Cherry Laurel Court Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 X Married 2 X No Specify: White Baltimore, Maryland 21215-0036 1 X Yes 2 No Specify: þ 3 Widowed 4 Divorced Mexican "natural", Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be and Mental Margie Orlivia Sedillo Robert Gailbraith Myers 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Important: If them 27 Is any injury or other traum. 8401 Cherry Laurel Court, Laurel, Maryland 20723 Christopher Mark Curp /spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) June 1 Pages 1 ament of He 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☒ Removal from State Rio Rancho, New Mexico 4 ☐ Donation 5 ☐ Other (Specify) Vista Verde Mem. Pk. 2011 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 21. Signatur of Funeral Service Urensee 313 Talbott Ave. Laurel, Maryland 20707-4389 M00773 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failyre. List only one cause on each line. Approximate Interval Between Immediate Caus Fin Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dust to for as a consequence of The law requires that the death certificate be executed physician and as the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical as attending IF FEMALE: nse 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy ate has been signed by the atten page 2 should be detached for in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by E IZNo 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 1 Yes Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) 1 X Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death. ours after death.
eral Director: At filled in by the fi 2 Accident 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide o the Funeral Discompletely filler Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title certifier D67721

10 Ely

DHMH 17 Rev 1/2001

State

Registrar

600 North Wolfe St. Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Day, Year)

3

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-1 - For State Registrar Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Month Physician/ 16:58 loyd odhmon 20 Medical 4a. Facility Name (if not institution, give street and numb 4b. City, Town, or Location of Death Examiner 4c. County of Death If Under 1 Year | If Under 24 Hrs. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Days Hours Min 62 Yrs 1949 Washington, DC **Director** 577-68-4935 Feb. Usual Residence of Decedent show 10a. State 10b. County notified at 10c City Town or Location 10d Inside City Limits Director 28a-f 1 Yes 2 X No Anne Arundel Laurel MD 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? event, the Medical Examiner must be Funeral 23a 20724 USA 246 Federalsburg S. items 2 death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

XX Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: White Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Diebolt Technician 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o ည Josephine Harvey Calvin L. Cookman, Sr. permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carlin Road, Hanover, MD 21076 7584 John P. Cookman/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🛛 Cremation 3 🗆 Removal from State cemetery, crematory or other place, Odenton, MD West Arundel Crem. 5/25/2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, Laurel, MD 20707 313 Talbott Avenue, M01103 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one fions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition VEIN Medical resulting in death) as a consequence of Examiner Visceration CENTREMINEN APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? for Month Day Year signed by the at d be detached for Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Director: After this certificate 2 💢 No 2X No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To the Hospital or Attending Physician: 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 🗌 No Other: 1. Inpatient 2. ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred ☐ Natural 5 Pending Bicycle crash/over handle 1 Yes 2 No 2 Accident 3:00 23/2011 Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) intersecta Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

Sy

State Registrar 31. Date filed (Month, Day, Year)

5/23

South

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Buchanon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #2&23gtate of Waryland Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death 2011 May 19 Physician/ 11:52 a M Mary C. Czerwinski Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Atlantic General Hospital Berlin 8. Date of Birth
(Month, Day, Year)
Dec 14, 1928 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🔀 F Months Country) Maryland **Director** 219-28-6850 82 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at filed within 72 hours after death with the Maryland Director 1 Yes 2 X No MD Baltimore Reisterstown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21136 U.S.A. 204 Highfalcon Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces þ 1 Never Married 2 Married Yes 2 🛭 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. I other than " Elementary/Seconday (0-12) Housewife Own Home permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ **Blanche** Fleming Charles Rinehart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bishopville, MD John Czerwinski Son 12626 Selby Road Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Mem Gard 5/21/11 Finksburg, Maryland 22. Name and Address of Facility 11824 Reisterstown Road 21. Signature of Funeral Service Licenses Reisterstown, MD ELINE FUNERAL HOME 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Clostridium Difficile Colitis Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Secusifially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last and -tran Due to (or as a consequence of) attending physician Physician/Medical that the death certificate be 11912011 Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No should be detached for Pregnant at time of death 15, P.O. ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page 2 s autopsy 1 Yes 2 No 219-28 - 613 25. Was case referred to medical director. 26. Place of Death (Check only one) examiner? Hospital: 1 Tyes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral 27. Man of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [only one f certifier 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D53612

State

Registrar

30. Name and address

31. Date filed (Month, Day, Year)

2011

24

12/14/198

H. Czcrwinski

1thway Dr Berlin MD 21811

rson who completed cause of death (Item 23a) (Type, Print)

Ruth Anna Cogley 11-02156 **UNK UNK**

ne or Print in Plack Indelible Ink Ensure All Copies Are Legible Please

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State of Maryland	/ Department of H	ealth and Ment	al Hygiene	

1- For State Certificate of Death Registrar Reg. No Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Medical Examiner Ruth Anne Cogley 0016 hrs March 20, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bon Secours Hospital Baltimore Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex **Funeral** Foreign Country) MD 217-31-7555 Months Hours Min. 07/15/1983 27 Davs Director 2 X F 1 M Yrs Usual Residence of Decedent III 10a State 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Arbutus 1 Yes 2 X No show mit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland parment of Health and Mental Hygiene.
portant: If item 27 is marked other than "natural", or items 23a or 28s-f sho Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1008 Stormont Circle 21227 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Armed Forces? White, etc. 2 X No White Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12 Receptionist Dental 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Ellis Odell Cogley Jr Laura Jane Mariner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1008 Stormont Circle Arbutus MD 21227 Laura Jane Green Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) other 1 Burial 2 X Cremation 3 Removal from State Atlantic Crem 05/27/11 Glen Burnie MD 4 Donation 5 Other Specify: 9 permit. 22. Name and Address of Facility Simplicity Crem & Fun Serv 21. Signature of Funeral Service Livens ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Medical failure. List only one cause on each line Between Onset and Death a Diabetic hyperglycemic ketoacidosis Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last gud Physician/Medical \square AMENDED 23a, pt.II, 27, per me, g915 6-3-11 sm attending physician a **X** UNPENDED Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. of Vital Records, P.O. Box 68760. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 Unknown Drug use Completed certificate has been 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy performed? death? page Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other this DOA 1 🗸 Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Fueral Director: A To the Fueral Director: A ' ... A filled in by the fu Division 1 X Natural 5 Pending 1 Yes 2 No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) determined (Specify) 4 Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 20, 2011 20 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

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		1- For State Registrar		Certific	cate of l	Death			Reg. No.		
Physic	ian/	Decedent's Name (First, Middle	Middle,Last)					2. Date of D			3. Time of Death
Medical Exam		MIGUEL	CRUZ					Month Day Year May 16, 2011			1815 hrs
		4a. Facility Name (if not institution	n, give street and n	umber)	4b	. City, Town, or L	ocation of De			County of [Death
		Johns Hopkins Hospita	al			Baltimore				N	/A
Funera	_	5. Social Security Number	6. Sex	7. Age (In yrs. last bi	rthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of	Birth(MM/D		9. Birthplace (State or
Directo						Months Days	Hours	Vin. 11/0	4/19	71	Foreign E T ount S) ALVADOR
		N/A	1 M 2 F	36	Yrs.			11/0	4/17	/4	E43QALVADOR
b		Usual Residence of Decedent 10a. State 10b. County		10c, City, Town	n or Location	n					10d. Inside City Limits
w any		,									1 Yes 2 No
Aaryland 28a-f show 1 at once,	5	MD N/	<u>A</u>	BA	LTIMO						
/ary 28a-	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What	Country?
ith the Maryland 23a or 28a-f sho notified at once.	盲	3415 E. LC	MBARD S	TREET		212	24		EL	SALV	ADOR
hours after death with the Maryland "natural", or items 23a or 28a-f she Examiner must be notified at once	Funeral	11. Marital Status		cedent Ever in U.S.	13. Was	Decedent of Hisp	anic Origin?	(Specify Yes or	No- 1		American Indian, Black,
leath r iten	١١	1 X Never Married 2 Ma	rried Armed F	2 X No	If Yes	s, specify Cuban,	Mexican, Pu	erto Rican, etc.)		White, e	etc.
fter of 17,000 ler user us	Y.	3 Widowed 4 Dive	orced If Yes, Give Ye		1 X Y	res 2 No	specify: S.	ALVADO	RAN S	Specify:	WHITE
136 thin 72 hours afte 1e. than "natural", edical Examiner	d b	15. Decedent's Education (Spec	or Dates: ify only highest gra	de completed) 16a		Usual Occupation			16b. Ki	ind of Busin	ness/Industry
2 -	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during mos	st of working life. I	DO NOT use	retired)			
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215- e filed tal Hy, ked of		MIGUEL AN	GEL CRU	IZ			MARIA	RUFI	NA	CRUZ	
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than	P	19a. Informant's Name/Relationsh	nip (Type, Print)	19	9b. Mailing A	Address (Street	and Number	or Rural Route N	lumber, City	y or Town,	State, Zip Code)
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Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other ti		21. Signature of Foreral Service	Licensee	an	LI Na	me and Address of LLY & Z	EILEF	R INC.	FUNE	RAL	HOME
		23a. Part I. Enter the disease, or	1/100	ee C	1190	JI EAST	ERN F	VENUE,	BALL	O,MD	21231
Physician		23a. Part I. Enter the disease, or failure. List only one cause	on each line.					ac or respiratory	arrest, snot	x, or near	Between Onset and
Examine		Immediate Cause (Final disease	a. Compli	cations of	head	injurie	s				Death
, , , , , , , , , , , , , , , , , , , ,		or condition resulting in death)	Due to (or as	a consequence of):							
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87 tifica ng pl	5	23b. Was decedent pregnant in th past 12 months?		birth		I death 3	gnancy	Month Day			
Sox 68 death certificate e attending for use as	100		4 Preg		\equiv	er (Specify)			- 1		
Box 68° e death certificate attending ed for use as	Physiciar	1 Yes 2 No 9 Unk	nown g Unkr	iown							
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Division of Vital Records, rate or Attending Physician: The law require is after death. Di Director: After this certificate has been siled in by the funeral director, page 2 should be do in by the funeral director, page 2 should be		27. Manner of Death 1 Natural 5 Death	(Mont	e of Injury h, Day,Year)	. Time of Inj	· I	at Work?	28d. Describ			
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ViS or A of A Direc	≝	3 Suicide 6 Coul	not be	ce of Injury - At home,	farm, street,	, factory, office bu	ilding, etc.	28f. Location or Town	n (Street an n, State) 2	46 S	or Rural Route Number, City Broadway St.
Divis Divis pital or At ours after d reral Direct filled in by	Certification:	4 Homicide deter	mined (Specify	street				BAlti	more,	Md.	Broadway St.
Hos Fun		29a. Certifier 1 Certifying Pr	ysician: To the be	st of my knowledge, de	eath occurre	ed at the time, dat	e and place,	and due to the c	ause(s) and	d manner as	s stated.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Exam	niner:On the basis and manner	of examination and/or stated.	investigatio	on, in my opinion,	death occurr	ed at the time, da	ate and plac	ce, and due	to the cause(s)
F ≯ F 3	¥	29b. Signature and title of certifie				29c. License	number		29d. D	ate signed	(Month, Day, Year)
		ano IZ_				O.C.N	1.E.		May	17, 201	1
		30. Name and address of person	who completed car	ise of death (Item 23a))						
				Examiner 900		nore Street, E	Baltimore,	MD 21223			
	tate			egistrar's Signature							
	strar	MAVO	1 2011	Jensua p	. 490	ake					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MAY 22, 2011 **JOHN** VIRGIL CASKEY 4:30 a^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ST. JOHN NEUMANN RESIDENCE TIMONIUM BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Days Hours Min AUGnth, Day Y Year)917 °OHTO 580-16-6703 93 **Director** Usual Residence of Decedent 28a-f show 10a State 10c. City. Town or Location with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits Director MD BALTIMORE 1 Yes 2 X No TIMONIUM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2300 DULANEY VALLEY ROAD 21093 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. þ 1X Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after ☐ Yes 2 No Specify. Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meany injury or other traumatic event, the Meany injury or other traumatic approx. College (1-4 or 5+) 5 + Elementary/Seconday (0-12) PRIEST CATHOLIC CHURCH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHARLES WILLIAM CASKEY ADA **ISABELLE** BOWDEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) REV. GERARD SZYMKOWIAK 2300 DULANEY VALLEY ROAD, TIMONIUM, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) GETHSEMANI CEM. 5/28/11 LIMA. OHIO 21. Signature of Fundamental rvice Licensee Name and Address of Facility
LLLY & ZEILER INC. FUNERAL HOME 7<u>00</u> CONKLING ST. BALTO , MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sch line Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Pnysician/ MOI ears Medical Due to (or as a co Examiner ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine a a consequence of): Cause (Disease or iinjury that initiated events physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical JOHN V. CASKEY MAY 22, 2011 Division of Vital Records, P.O. Box 68760 After this certificate has been signed by the attending *f* funeral director, page 2 should be detached for use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other, significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy performed? Yes 2 No After this certificate has 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 **X**No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 1 Continuing Nurse Prections To the pest of my king which is death and at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier License number 30. Name and address of person who completed cause of death (Item \$3a) (Type, Print)

ERNESTINE WRIGHT, MD 2300 DULANEY VALLEY ROAD, TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Regi ar's Signature State Registrar

			pe or Print in Bla					
		For 1 - State Registrar	State of Maryland /	Department of Certificate of		ental Hygiei Reg.	0011	10000
Physicia	an.	Decedent's Name (First, Middle, Last)		0 +		2. Date of Death	Day Year	3. Time of Death
/Medic	al	4a. Facility Nam (If not institution, give stre	AN C	4b. City. Town.	4/U or Location of Death	MAY 2	9 20 V 4c. County of Deat	10°00 A M
Examin	er	MANOR CARE		Rose	2dAle		BALT: M	ORC
Funeral Director		5. Social Security Number 6. Sex 1 M	7. Age (In yrs. last	birthday) If Under 1 Year Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birt	hplace (State or Foreign buntry)
pu "		Usual Residence of Decedent 10a. State 10b. County	10c, City, To	own or Location		001, 10 1		10d. Inside City Limits
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with the	Director	10e. Street and Number	+ 1	10f. Zip Code	27	10g.	Citizen of What Co	untry?
death	Funeral	11. Marital Status 12.	Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of	Hispanic Origin? (Spettan, Mexican, Puerto	ecify Yes or No-	14, Race - Ame Black, White	
s after	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ∰ No If Yes, Give Year or Dates:	1 □Yes 2 ■ No		1110411, 010.)	Specify: W	hite
72 hours after death with the Maryland 72 hours after death with the Maryland "natural", or items 23a or 28a-f show kilcal Eraminar rust by routhed at	eted	15. Decedent's Educati (Specify only highest grade co	on 1	6a. Decedent's Usual Occu (Give kind of work done	during most of working		. Kind of Business/	Industry
within jiene.	Completed		College (1-4or 5+)	life. DO NOT use retire	lorker	O	vens I	llavis
be filed tal Hyg d other event,	Be	17. Father's Name (First, Middle, Last)	D	11	18. Mother's Name	(First, Middle, Maid	den Surname)	' 11
or is, wally falled within 72 hours after death with the Maryla ges 1 and 2 should be filed within 72 hours after death with the Maryla tof Healts and Martal Hygiens Harland and the standard other than "natural" or items 23a or 28a-4 show or other traumatic event, it a Mardical Empriment rust by multipled at	ပ	19a. Informant's Name/Relationship (Type.	Print) (Ni ece) 1	9b. Mailing Address (Stree	et and Number or Rura	AN-R al Route Number, Ci	ty or Town, State, 2	Alley Zip Code)
and 2 and 2 m 27 is in m 27 is in her train		DARlene Buzgi	erski 1	01755	unter	Ave Ru	sedsle	MA21237
Pages 1 nent of H int: If Iter		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	oval from State	e of Disposition (Name of etery, crematory or other plants			Location - City of	Town, State
permit. Pages 1 and 2 Department of Health Important: If Item 27 any injury or other tr once.		21. Signature of Furreral Service Licensee	DACE	22. Name and Addi	ress of Facility	ChOTN	acki F	H25 PA
2 AO E 8 9		23a. Part 1. Enter the disease, or complicati	ions that caused the death.	1005 DG	endalk A	or respiratory arrest,	timone	Approximate
Physician		shock, of heart failure. List only one of Immediate Cause (Final disease or condition	cause on each line.	nonony i	nest			Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequence	.//	61/			
D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence		.			
be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events c resulting in death) Last	Que to (gr as a consequence		ciden			
the buri		L d	Abrhemer.) - Kloulde	v Cona	٠١		
Attending Physician: The law requires that the death certificate be referor. After this certificate has been signed by the attending physicial by the funeral director, page 2 should be detached for use as the bur	Physician/Medical	IF FEMALE: 23c. 23c.	If yes, outcome of pregnancy				23d. Date of de	livery
re death the atte	sicia	in the past 12 months? 1 □ Yes 2★No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deatl 9 ☐ Unknown				Month	Day Year
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w requires to the signer should be considered.	ted by					1 ☐ Yes	2 No 3 P	robably 4 Unknown
he law i e has b	Completed					24a. Was an autopsy performed	?// death?	utopsy findings available completion of cause of
sian: Ti ertificat ctor, pa	Be Co	25. Was case referred to medical examiner?			26. Place of Death	1 □Yes 2 ↓ n (Check only one)	Mo 1 □ Yes	3 2□No
Physic r this or	ဍ	1 ☐ Yes 2 No Hos	28a. Date of Injury 28	Outpatient 3 DOA O		me 5 Residence		ecify)
ending eath. pr: Afte the fune	atior	1 Natural 5 Pending investigation	(Month, Day, Year)		ork? □Yes 2□No			
l or Att after de Directu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, factory, office		28f. Location (Stree City or Town, S		ural Route Number,
fospita 4 hours funeral ely filled		(Check only 2 Medical Examiner	ian: To the best of my knowler: On the basis of examination					
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:	Medical	one) 29b. Signature and title of certifier	and manner stated.	29c. Licer	nse number	29d.	Date signed (Mon	th, Day, Year)
) fee ·		Do	70785	. V	MY 30H	2011
J		30. Name and address of person who comp		la) (Type, Print) N. CU (/W S	(R SCF 30	S BARTIN	ruce til	21201
Sta	- 4	31. Date filed (Month, Day, Year)	32. Registrar's Signature	A Barker				
Registra	ar	MAISLZ	UII LENGURS	la. Character				

For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month MAY 24 ^{Day} 2011 JOSEPH ANTHONY DRESSLER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 7. Age (In vrs. last birthday) Funeral 1 M 2 D F Days Hours Min. 150-24-7781 78 Yrs. Director 1933 Usual Residence of Decedent or 28a-f shov 10a. State 10h County 10c. City, Town or Location must be notified at **Funeral Director** Fairfax Virginia | Vienna 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b. once. 349 Lawvers Road, NW 22180 U.S.A.12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Xves 2 ☐ No 1958 If Yes, Give to Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 5+ Officer - Captain U.S. Navv Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Dressler Anthony Anne Bowen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas J. Dressler/Son 234 Lawyers Road, NW, Vienna, Va. 22180 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) /27/2011 Money & King Cremat**i**on Chantilly, Virginia Gary R. Down & Pray to Ge and Address of Facility . Signature of Funeral service Licensee Money & King Funeral Home,Inc ve.. Vienna. Va. 22180 CCO23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months? Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 줊 Division of Vital Records, Completed 24a. Was an has autopsy performed' Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 XNo မ 1 🙀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 4 сотрleted filled in by the f ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 0101241237 (VA) 2011 NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

6030

3. Time of Death

9. Birthplace (State or Foreign Country)
New Jersey

10d. Inside City Limits

Approximate Interval Between

Onset and Death

1 X Yes 2 □ No

MONTGOMERY

Black, White, etc.

12:35 PM

State Registrar 29b. Signature and title of chific

ALI MASSOUMI

MAY 31

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

MID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Margaret M. D'Antonio ; 00AM 2011 03 MAY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ST JOSEPH MEDICAL CENTER TOWSON BALTIMORE Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 🗆 M 2 🗶 F Hours 215-12-4780 2/21/1922 **Director** 89 Maryland Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Timonium 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2202 Boxmere Road 21093 U.S.A. 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian Black, White, etc. 1 Never Married 2 X Married þ 1 ☐ Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: White 3 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour popartment of the that hand Mental Hygiene. Important If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William H. Peters, Sr. Miriam C. Eccleston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert D'Antonio, Ph.D. / Son 19040 Graystone Road White Hall, Maryland 21161 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🔯 Other (Specify) Entombment Dulaney Valley Mem. 5/28/2011 Timonium, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ PANCYTOPENIA disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** MYELODYSPLASIA Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of Exami cause. Enter Underlying Cause (Disease or iinjury that initiated events -trar Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ or Attending Physician; The law requires DEEP VENOUS THROMBOSIS 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? AORTIC STENOSIS 24a. Was an page 2 performed? Yes 2 No 1 🗌 Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? (Month, Day, Year) 5 Pending injury within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident 2 No Investigation 1 Yes 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cent 29c. License number D24034

d 1

DHMH 17 Rev 7/2009

Registrar

7601 Osler Drive Towson, Maryland 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Timothy Low,
31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 28,2011 12:54A. M Loretta M. Dembinsky Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Balto. Nottingham 8803 Parlo Road Social Security Numbe 1 Year If Under 24 Hrs. If Under 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 X F Months Days Hours August 1,1930 Maryland **Director** 212-28-0458 80 Usual Residence of Decedent 28a-f show 10a State ms 23a or 28a-f sho must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Nottingham Md. Balto. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21236 **USA** 8803 Parlo Road or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. the Medical Examiner Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐XIo Specify: "natural", Specify Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 ral Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Baltimore Federal Fin. Vice President other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mildred K. Heck Paul A. Zelinka Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8803 Parlo Road Nottingham, Md. 21236 permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Clinton R. Dembinsky Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 1 Burial 2 Cremation 3 Removal from State Holy Redeemer 5-31-2011 Balto, Md. 21236 4 Dopation 5 Other (Specify) of Funeral Service License 21. Signatu 22. Name and Address of Facility Schimunek Funeral Home 7) 9705 Belair road Nottingham, Md. It 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of): physician s the burial Physician/Medical Box 68760 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day the 9 Unknown 9 Unknown P.0. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 - No certificate 1 Yes 2 No 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 2 No 1 Yes Accident Investigation Director: / within 24 hours after degroups to the Funeral Director completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and itle of certifier MD 71040 C_{I} 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

+RIATH"

31. Date filed (Month, Day, Year)

KUMAR

6701

BALTIMORE

2120

North

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 16942 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 25, 2011 1859 Ansuyaben S. Dave Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 102 Shannon Court #203 Prince George's Laurel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthdav) 9. Birthplace (State or Foreign **Funeral** Country) India Months Days Hours January 20 1 □ M 2 😿 F Yrs. 84 Director 220-57-9710 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at 1 Yes 2 No Maryland Prince George's 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be 102 Shannon Court #203 India 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ← No 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Asian Indian "natural", Completed 3 ₩ Widowed 4 □ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the N any injury or other traumatic event, the N once. Own Home <u>Homemaker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Vrajalal Dave Prabhaben Dave 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shobhna S. Dave/Daughter in Law 102 Shannon Court #203, Laurel, Maryland 20707 20b. Place of Disposition (Name of cemetery, crematory or other place).
West Arundel 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 27, May 2011 Crematory <u>Odenton, Maryland</u> 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 A2VE MO1386 Par 1, Enter the disease, or comp shock, or that failure List only seations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Immediate Cause Physician/ disease or condition resulting in death) Many Years Coronary Artery Disease Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami that the death certificate be executed the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Pregnant at time of death 1 Yes 2 9 Unknown 2 X No the Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 should be 1 \square Yes 2 $\frac{1}{2}$ No 3 \square Probably 4 \square Unknown Debility, Anemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy page 1 ☐ Yes 2 🔀 No 1 ☐ Yes 2 🔀 No Be 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🕱 No |요 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 😾 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending work? iniury 1 🔀 Natural 5 Pending 2 Accident
3 Suicide Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

SM

State

326

<u>Rajkumar G. Bhojraj</u>

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Maryland 21215-0036

Baltimore.

Box 68760

P.O.

Records,

of Vital

Division

5632

D23181

<u>Annapolis Road, Bladensburg, Maryland 20710</u>

May 26, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Neshazo Wayne 6:17 AM 201 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4c. County of Death University of Manyand Medical Cete Baltimore 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** M 2 ☐ F 54 Days Min. Country Hours Aug. 29,1956 Director 212-70-1055 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits be notified 28a-f MD 1x Yes 2 No Baltimore 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4628 Northwood Drive 23a 21239 "natural", or items 23 USA 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces þ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify Black 3 ☐ Widowed 4 ☑ Divorced Completed Year or Dates. marked other than "natu matic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Associated Adminis Elementary/Seconday (0-12) College (1-4 or 5+) tration LLC 12th Scanning Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Wallace DeShazo Ernestine Winkler 19a. Informant's Name/Relationship (Type, Print) daughter) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S KiCher Linnea DeShāzo 200 Oak Leaf Way Balto,Md. other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🛣 Burial 2 □ Cremation 3 □ Removal from State ArbutusMemorialPark June2,2011 Balto.Md 4 Donation 5 Other Specify Name and Address of Facility Calvin B. Scruggs Funeral Home 21213 Fart 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. at enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Hemorrhag (upper Physician GI disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Ducito (or as a consequence of). burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical 68760 IF FEMALE use 23b. Was decedent pregnant Box (23d. Date of delivery for in the past 12 months? Month Dav Yes 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sate has been signed page 2 should be de 23e. Did tobacco use contribute to the cause of death? Completed by cholangio carcinomes Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available autopsy performe prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Yes 2 Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗹 No Other: al or Attending Physics after death.
I Director: After this or မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Hospital 24 hours Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific

Registrar

DHMH 17 Rev 7/2009

Greene St- Baltimore MD 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 29, Physician/ Dorothy Ehria 2011 May 1:40AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Baltimore **Examiner** 4b. City, Town, or Location of Death Towson Gilchrist Hospice 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Months Hours 217-22-2900 1 □ M 2 🔽 F 86 December 3 ear) 1924 Mary Tand Director Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8408 Hallmark Circle 21234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify. White If Yes, Give 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Family Grocery Store Grocery Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Joseph Siemek Veronica Yurek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clifford C. Ehrig/Son 8408 Hallmark Circle Baltimore Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or other 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Parkwood Cemetery 6/1/11 Baltimore Maryland 22. Name and Address of Facility Leonard J. Ruck, Inc. of Fufferal Service Licensee 5305 Harford Road Baltimore Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to ras a nsequence of): Examiner Sequentially list conditions Examine ii any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Live Birth 2 Fetal death in the past 12 months? Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy death? performed? certificate Yes 21 A Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 10 ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b, Signature and tit 29 c. License number 29d. Date signed (Month, Day, Year) D71040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARATHI 6701 N CHARLE KUMAR 4105 BALTIMORD MD 21206 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Month Physician/ 2011 May 11:35am [™] Enwright James Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Baltimore 8911 Middlebrook Court Randallstown 8. Date of Birth (Month, Day, Year, Aug. 2, 1 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 5. Social Security Number 6. Sex 1 XM 2 ☐ F Age (In yrs. last birthday) **Funeral** Months Davs Hours Yrs 78 ĭ̈́932 028-24-1898 Aug. **Director** Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 Yes 2 X No Randallstown Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21133 8911 Middlebrook Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ever in U.S. Black, White, etc. Armed Forces 1 Never Married 2 X Married X Yes 2 Yes, Give 2 No Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Divorced 4 Divorced Year or Dates. Korean 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) ould be filed within 72 nd Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Social Security Admin. Supervisor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Irene Poisson John Francis Enwright and 2 should b Health and Me tem 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8911 Middlebrook Court, Randallstown, MD 21133 Wife Joan Enwright 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition permit. Page 1 a Department of I Important; If its any injury or of 1 Burial 2 X Cremation 3 Removal from State Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 5/24/11 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ELINE FUNERAL HOME 11824 Reisterstown Rd. Reisterstown, MD 21136 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate 23a, Part 1. Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of) attending physician for use as the burial Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Year in the past 12 months? Month Day Hospital or Attending Physician: The law requires that the death Pregnant at time of death Yes 2 No detached 9 Unknown g Unknown Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? s been signed b should be deta Be Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 2 🗆 No 1 Tyes Yes 26. Place of Death (Check only one) **Division of Vital** Was case referred to medical Other: 2 X No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 1 Tes 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of D. ath 28a. Date of injury Certificate: (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No Natural 5 Pending M n 24 hours after death.

E Funeral Director: A bleted filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc..(Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the F only one) 29d. Date signed (Month, 29b. Signatur and title of certifie

State Registrar

DHMH 17 Rev 7/2009

Name and address of

31. Date filed (Month, Day,)

of death (Item 33a) (Type, F

11-03545 Milton Eades, Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certifi	icate of	Death			Reg. N	o.			
Physici	an/	1. Decedent's Name (First, Middle,Last) 2. Date of Death								3. Time of Death			
Medical Exam		Milton Eades Jr							2011	y Yea	٢	1053 hrs	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death							_	4c. County of	of Death		_
	Mile Post 85.37 Middle River								Baltimor		ntv		
-			6. Sex	7. Age (In yrs. last b	oirthdau)	If Under 1 Year	If Under 2	24Hm 9 Date of	Dirth (MI				_
Funeral		5. Social Security Numberunk		7. Age (in yrs. last t	ortiliday)	Months Days		Min.	DILITI (MI	M/DD/TTTT	Foreign	nplace (State or	
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		Usual Residence of Decedent											_
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fter fr. o		3 Widowed 4 Div	vorced If Yes, Give Ye	er	1	Yes 2 No	specify:			Specify:	bla	ick	
5-0036 led within 72 hours af Hygiene. other than "natural the Medical Examin	d by	15. Decedent's Education (Spe	or Dates: ecify only highest gra	ide completed) 16a	a. Decedent	's Usual Occupation	on (Give kin	nd of work done	16b	. Kind of Bus			_
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a, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-7 she trammatic event, the Medical Examiner must be notified at once		Melvin Eade	s/brother					liddle Ri					
Hear Hear		20a. Method of Disposition			e of Disposit atory or oth	tion (Name of ceme	etery,	Date	200	c. Location -	City or T	own, State	
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Baltimore, MD 21215-00 permit. Pages I and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other injury or other traumatic event, the IM.	l II	21.00	<i>d</i> [Director	_sra	te Anator	my Bo	ard 655 W	І. В	altimo	ore	Street	1
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Physician		fature. List only one cause		caused the death. Do	not enter the	e mode or dying, si	such as card	diac or respiratory a	arrest, s	nock, or nea	ırı	Approximate Interva Between Onset and	
/Medical ≟xaminer		Immediate Cause (Final disease	a Multip	le Injurie	28							Death	
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3760, ificate be ig physic s the bur	Ĭ.	IF FEMALE:		outcome of pregnanc			_		2	3d. Date of			_
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Box 68' e death certificate attending ed for use as to	<u>S</u>	1 Yes 2 No 9 Uni		nant at time of death	5 Oth	er (Specify)							
the defe	Physiciar		a nuku										
Division of Vital Records, P.O. Box 68 Hospital or Attending Physician: The law requires that the death certi 24 hours after death. Funcral Director: After this certificate has been signed by the attendin tely filled in by the funeral director, page 2 should be detached for use at		Part II. Other significant condit	ions contributing t	o death but not result	ing in the ur	nderlying cause giv	ven in Part I				_	ne cause of death?	
P.C.	d by							1Y	es 2	√ No 3	Proba	ibly 4 Unknown	
Division of Vital Records, talor Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed							24a. Wa				ppsy findings available	е
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Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical			st of my knowledge, d									
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_	-	30. Name and address of person	who completed care	se of death (Item 22a)								\dashv
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1443 Physician/ May Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death County General Towar Howard Colymbia Social Security Number If Under 1 Year I If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Min. 1 - M 2 XX 71 12¹¹10¹1939 470-44-5253 **Director** Minnesota Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked outher than "natural", or items be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Columbia 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21044 U.S.A. 10968 Swansfield Road . Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Completed by Black, White, etc. 1 Never Married 2XX Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Specify: 3 Divorced 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Information Specialist Advertising Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Delora Meiner Clifford H. Meyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10968 Swansfield Road Columbia, MD 21044 James Filipczak (Husband) 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Barretenmorratory or other place) 1 Burial 2 XXCremation 3 Removal from State 5-29-2011 4 ☐ Donation 5 ☐ Other (Specify) Washington Crematory Laurel, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Witzke Funeral Homes, Columbia, MD 20145 5555 Twin Knolls Road 23a. Part 1. Enter the disea e or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ gortic disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Day Year by the a Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate ha irector, page 2 performed? Yes 2 2 🗌 No 1 Tyes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 **X**No Hospital Other: မ 1 🗌 Yes 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Accident Investigation 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify)

Registrar DHMH 17 Rev 7/2009

State

Medical

29a. Certifier

(Check

only one) 29b. Signature

ause of death (Item 23a) (Type, Print)

inggeler, Mo

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

5755 Cedar Lane, Columbia, MO 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ V. May 26, Maxwell Frye, Jr. 2011 2:31 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Age (In vrs. last hirthday 8. Date of Birth **Funeral** XXM 2 Months Hours 82 Director 217-20-4147 Baltimore, MD July 1928 Usual Residence of Decedent or 28a-f show be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Queen Anne's Grasonville 1 Tyes 2XXNo 10e. Street and Number 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 816 Chester River Drive 21638 USA ıral", or items 2 I Examiner mus 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces' Black, White, etc. Completed by 1 Never Married 2 X Married 1 X Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. White 3 Widowed 4 Divorced Specify Year or Dates. WWII Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Police Officer Law Enforcement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Maxwell V. Frye, Sr. Emma Leona Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Jane Frye Wife Chester River Drive Grasonville, MD 21638 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State permit. Page Department 4 Donation 5 Other (Specify) June 3,2011 Crownsville, Maryland Maryland Veterans 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation M01121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Services PA: 2nd Ave SW: Glen Burnie. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ neumania disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed has been signed by the attending physician and e 2 should be detached for use as the burial-transi Dause (Diseaso or imjur that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant a 5 Other (specify) Month Dav Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 certificate ! 1 ☐ Yes 2 ☐ No 25. Was case referred to cal examiner?
1 ☐ Yes Be 26. Place of Death (Check only one) Hospital Other: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Mann of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred inlun Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Acciden☐ Suicide Accident Investigation within 24 hours after deatl 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0005820 26 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) How top 32. Registrar's Signature State

ORIGINAL

Registrar
DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 21, 2011 Martha J. Fretwell 10:30 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Manor Care Dulaney Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 X F Months Days Hours Min. 82 213-50-0880 December 15, 1928 West Virginia **Director** Usual Residence of Deceder 28a-f shov 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 🗆 Yes 2 🙀 No Baltimore Parkville 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 8800 Walther Boulevard Apt. 1007 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 X Never Married 2 Married 12 should be filed within 72 nours and alth and Mental Hygiene.

A 27 is marked other than "natural", o 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. White 3 🗌 Widowed 4 🗌 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) House Cleaning 10 Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank Sylvester Fretwell Margaret Severe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl
Department of Health a
Important: If item 27 is
any injury or other tra Frank E. Fretwell/Brother 8800 Walther Boulevard #1007 Parkville MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillton Service Corp. 5/24/11 Towson Maryland 21234 Funeral Service Licens 2. Name and Address of Facility Leonard J. Ruck, Inc 5305 Harford Road I Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each lir Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Atheros clerot o Physician/ Cardiovasula Medical Examiner Sequentially list conditions, Due to for esta montecisames offe cause. Enter Underlying Cause (Disease or linjury Exami Hospital or Attending Physician: The law requires that the death certificate be executed and-trar that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death the g Unknown g Unknown P.O. been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has performed? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No မ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending neral Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) won-0 30. Name and address of person who completed dause of death (Item 23a) (Type, Print) Soute 31. Date filed (Month, Day, Year) er's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 45 Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore eason tospice 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 1 Days Min. 220-20-1879 Country) **Director** 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at **Funeral Director** Baltimore 1 XYes 2 ☐ No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Page 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Completed 3 Widowed 4 □ Divorced Specify: Year or Dates. is marked other than "natur aumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) N7A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. ithonia 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Dwings Mills, MD 5-31-2011 Donation 5 Other (Specify) re of Funeral Service License 22. Name and Address of Facility March F/H Signat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line m diate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or impury that initiated events the burial-tran resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Yes 2 No 1 Yes 2 g completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has 2 🗌 No 1 Tes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DCA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending iniury s after death. 2 Accident 1 Tyes Investigation 2 🗌 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier 📆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Praction To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ma Physician/ 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 407 ALTO ROAD BALTIMORE If Under 24 Hrs. 7. Age (In vrs. last birthday **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 3-88-0670 Days Hours Min. 1 🗆 M 2 🗙 F **Director** 18 MARI LAND Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f BALTIMORE 1 Yes 2 □ No MD 10e. Street and Number r items 23a or ner must be n ō 10g. Citizen of What Country? Funeral U.S.A. 21216 ı "natural", or iten ledical Examiner r Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 ☐ Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify. Specify: BLACK Completed 3 Divorced of Health and Mental Hygiene. I item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SERVICES WORKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ GRANT JAMES AMANDA 19a. Informant's N me/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MOTHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or otl 1 Burial 2 Cremation 3 Removal from State CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) LANDSCLOWNE MARVIAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE DERRICK C. JONES FILL, P.A HGTS. AUE. BALTIMORE, MARYIAND'S 23a. Part 1. Enter the disease, or complications th shock, or heart failure. List only one cause or caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ch line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ 16 disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or ilinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🔑 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မှ 1 \square Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of De th 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 🗆 No Accident
Suicide Investigation Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spec/fy) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce Name and address of person completed cause of death (Item

State Registrar 31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death GNERRO Physician/ 9:45 AM MILL Medical 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltinne Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sept. D28 1 🗶 M 2 🗆 F Months Hours ear) 1926 Washington, DC 84 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location items 23a or 28a-f sho ner must be notified at 10d. Inside City Limits Director MD N/A Baltimore City 1 X Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21264 USA 1300 S. Elwood Ave. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ò 1 ☐ Yes 2 🕱 No If Yes, Give þ 1XXNever Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify White "natural" Completed 3 Divorced Year or Dates 27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) English Professor Education 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental I ည Alessandra Landi Antonio Gnerro permit. Page 1 and 2 should Department of Health and Me Important: If item 27 is mar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emmitsburg, MD 21727 333 S. Seton Ave. Sister Maria Gnerro, D.C./ Sister injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Hilltop Service Corp. Towson, MD 21. Signature of Funeral Sen 22. Name and Address of Facility 5305 Harford Rd. any MD 21214 Baltimore, Leonard J. Ruck, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, it doing to immediate cause. Enter Underlying Cause (Disease or linjury Examine nding physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ atten for u in the past 12 months? Month Day Year Pregnant at time of death ate has been signed by the a page 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 Yes 26. Place of Death (Check only one) the funeral director, Be 25. Was case referred to medical examiner? Other: 2/ No 유 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury death. 1 ☐ Yes 2 ☐ No Accident Investigation after death 6 Could not be Suicide within 24 hours after de

To the Funeral Directo

completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of exam mination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie

State Registrar 32 Registrar's Signature

erson who completed cause of death (Item 23a) (Type, Print)

AN, MO 301 ST. Paul ST.

12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^D2^y011 Physician/ Raymond D. Griggs May 19, 12:15PM Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Genésis Heritage Center Dunda 1k Baltimore 5. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X**□ M 2 □ F Months Days Hours Min. (Month, Day, Year) Director 198-12-2866 85 Pennsylvania August Usual Residence of Decedent If than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland | Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7 Woody Rd. 21221 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry should be filed within 72 l n and Mental Hygiene. **7 is marked other than "n** (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Trucking N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev Robert Griggs Viola Daland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2812 Creston Rd. Dundalk, Maryland 21222 19a. Informant's Name/Relationship (Type, Print) Mr. Jerry J. Bauer (Friend) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Memorial 5/23/2011 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from the second control of the second control Timonium, Maryland Denation 5 Other (Specify) signature of Funera 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications to t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequenc of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): ending physician are as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? OBSTRUCTIVE Records, 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy performed Yes 2 death? 2 🗌 No To the Hospital or Attending Physician: Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 2 No Other: 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work' 5 Pending injury thin 24 hours after death.

the Funeral Director: After properties of the function of the func 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month

elof depth (Item 38a) (Tybe, Cript) - A

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State 16954 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Month Physician/ 2011 Michael Gavel Jr. 18:37 P™ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Nov. 12 Funeral 9. Birthplace (State or Foreign Months Days Hours Min. 1 X M 2 D F Year Director 218-44-5430 944 Maryland Nov. Usual Residence of Decedent 28a-f show with the Maryland 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 Yes 2 No Baltimore <u>Maryland</u> Baltimore ō 10e. Street and Number 10f. Zip Code an "natural", or items 23a or Medical Examiner must be 10g. Citizen of What Country? 911 Elton Avenue United States death 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces' þ 1 Never Married 2 X Married 1 Ves 2 No Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Specify: Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry should be filed within 72 in and Mental Hygiene.

27 is marked other than "r (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Law Enforcement 12 years Maryland State Trooper traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Michael T. Gavel, Sr. Norma J. Landon Department of Health and Important: If item 27 is n any injury or other traum once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Helen M. Gavel</u> (Wife) Elton Avenue Baltimore, Maryland 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memoria1 Gdns. 5/26/2b11 Middle River, Md. Signature f Fu 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc
7922 Wise Avenue Dundalk, Maryland 21 Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death 24 hrs Ph_sician/ Sepsis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Bowel Necrosis 2 days Sequentially list conditions. if any, leading to immediate cause. E ter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed Small Bowel Obstruction 5 days and that initiated events resulting in death) Last Due to (or as a consequence of): physician a sthe burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 the attending plants the second t IF FEMALE 23b. Was decedent pregnant Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Vear Pregnant at time of death detached 9 Unknown 9 Unknown s been signed by tl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed this certificate Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 💢 No ၉ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide 1 \square Yes within 24 hours after death

To the Funeral Director: A

completed filled in by the fi 2 🗌 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1/XX Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe RES-000 May 20, 2011 211 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul 4940 Eastern Avenue, Baltimore, MD Ravi Waldron MD 21224

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Pacadent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 7:34pm /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltimore N/AIf Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** XXM 2□F Days Hours Director 25. 85 1926 219-22-6906 Pennsylvania Mar. Usual Residence of Decedent the Maryland 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified 1 Yes 2 XNo Director Baltimore Maryland Dunda1k 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 23a or 8211 Dundalk Avenue Funeral 21222 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or Ite or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: à Specify: 3 Widowed 4 Divorced White Completed the Medicai 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 8 years Mechanic - Bethlehem Steel Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence S. Garman ည Myrtle E. Derr 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn A. Garman (Wife) 8211 Dundalk Avenue Dundalk. Maryland 21222 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages
Department of I
Important: If ite
any injury or of 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gdns. 5/26/2011

22. Name and Address of Facility Middle River. Md. of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222

nter the mode of dying, such as cardiac or respiratory arest, proximate Interval Between 23a, ort 1. Enter the disease of complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Opport and Death Immediate Cause (Final **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner as a consequence of): The law requires that the death certificate be executed monua ding physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 🗌 No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 No or Attending Physician; Be 25. Was case referred to medical 26. Place of Death (Check only one, Hospital: Other: 4 \square Nursing Home 2 1 🗌 Yes No Inpatient 2 ER/Outpatient 3 DOA မ 5 Residence 6 Other (Specify) Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 🗌 Yes 2 🗌 No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

4940 Eastern Avenue, Baltimore, MD, 21224

e and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Rea. No. 1. Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ Month Barbara Joan Gooding May 2011 6:40 P^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 12 Mills Road Gaithersburg Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days June 17. 1 🗆 M 2 🕱 F **19**37 Mary land **Director** 220-32-6936 73 Usual Residence of Decedent or 28a-f show 10a State be filed within 72 hours after death with the Maryland 10b. County 10c. City. Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 🙀 Yes 2 🗌 No Maryland | Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 12 Mills Road 20877 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black. White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: Completed White Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ည Edward S. Moyers Evelyn Burkett and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Earl Lee Gooding / Husband 12 Mills Road, Gaithersburg, Maryland 20877 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State cemetery, crematory or other place) Forest Oak Cemetery May 26, 2011 4 Donation 5 Other (Specify) Gaithersburg, Maryland 21. Signature of Funeral Service Licer kobert A. Pumphrey Funeral Home/Rockville, Inc. 300 W. Montgomery Ave., Rockville, MD 20850-2805 M00896 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease Years Sequentially list conditions, Due to for as a consequence of: if any, leading to immediate cause. Enter Underlying Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and -tran: Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Pregnant at time of death Dav Year 2 🗶 No the Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an as e 2 s er this certificate has eral director, page 2 performed^a 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 🔀 No ပ 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 X Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours and To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D21392 May 23, 2011 M

00 5h

State

Registrar

DHMH 17 Rev 7/2009

1201 Seven Locks Rd., Suite 111, Rockville, MD 20854

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatur

Patricia D. Kellog, M.D.,

3

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ^D2011 Physician May 23, 3:10 AM M Samuel Glazer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Friends Nursing Home SAndy Spring If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days 1√2 M 2□ F 049-05-4992 Director 99 Sept 10, 1911 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director MD Montgomery Sandy Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 17340 Quaker Lane #110 20860 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1∑Yes 2☐No If Yes, Give Year or Dates: 42-46 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify. Specify: white ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) pharmacist healthcare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sam Glasser Fannie Lebdin ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Tenney/friend 20879 9226 Bluebird Terrace Gaithersburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 3 ☐Removal from State 1 ☐ Burial 2 ☐ Cremation 4∏Donation 5 ☐ Other (Specify) director 21. Signature I Pineral Service 22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, other failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final Physician NANITION disease or condition resulting in death) /Medical Due to (or as a consequence of): ENILE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine PERT Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav 4☐Pregnant at time of death 5 Other (specify) 2 No 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an EO ABTIO autopsy performed? /es 22 No 5047 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury

Examiner certificate be executed burial-transit Box 68760, physician the attending nse for signed by the a d be detached f Division or Vital Records, P.O. has page certificate this il or Attending Patter death.

Director: After i After filled in by the within 24 hours a To the Funeral I To the Hospital

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nt: If item 27 Is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Examiner must be notifled

traumatic event, the Medical

mportant: If i

injury or

any

as

5 Pending investigation 1 Natural 1 🗌 Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1665 731

17348H-

JILVER

State Registrar

Medical

31. Date filed (Month, Day, Year)

CROC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 1921 ISTILLMAN RIHTUP 011 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death RING 320H IATI ILVER MONTGOMER CROSS Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Country) UNK 10 M 2 F Months Days Hours Min. (Month, Day, Year 126-46-834 Director Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s dical Examiner must be notified 1 Yes 2 No SILVER MONTCOMERY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral COLONIAI 8210 NIND N 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, If Yes, specify Cuban, Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates. Specify: Completed 3 Widowed 4 Divorced NOAL 12 UNK the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) WD UNK NUN t. Page 1 and 2 should be filed with rtment of Health and Mental Hygier rtant: If item 27 is marked other t njury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ UNK UNK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20910 1500 FORRST CROSS HOSPITA RD CLEN MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State Department of h
Important: If ite
any injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🕅 Other (Specify) in state 21. Sign to e of Euneral Service Licen (Adde) 22 Name and Address of Facility Board 655 W. Baltimore Street Director Raltimore, MD 23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ MYOCAR INFARC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner YPERTE Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed MORBID YBARS as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Be Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? for Year Month Pregnant at time of death should be detached 1 ☐ Yes ∠ ↓ 9 ☐ Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a, Was an autonsy this certificate has page 2 performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? Hospital Other: 2 No ျ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) work?
1 \(\sum \) Yes 2 \(\sum \) No 1 Natural injury 5 Pending e Funeral Director After Director After Plated filled in by the fun 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifier 0064008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NANDR FOREST CLEN HU503K 1200 egistrar's Signatur State Bar Registrar

MAY 22, 2011 10:45 p.m	Baltimore, Maryland 21215-003	
•		P
ALVIN GARTHRIGHT	cords, P.O. Box 68760	pay year ires that the death certificate he executed

		•	For State Registrar	State of Maryland		artment of F tificate of D			giene Reg. No.	Propinsion	16959
i	Physicia Medio		1. Decedent's Name (First, Middle, La Alvin C. Gar	st) thright Jr.				2. Date of De Month May		2011	3. Time of Death $10:45\ p_M$
	Examin			cility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Timonium						ty of Death Limore	
	Funeral Director		219-32-9904	Sex	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Feb. 14	th ly, Year) 1938	Coun	place (State or Foreign try) inia
	faryland Ba-f show tified at	Director	Usual Residence of Decedent 10a. State Md • 10b. County		Town or Loc					1	0d. Inside City Limits
	s 23a or 2	Funeral Dir	10e. Street and Number 1010 St Paul Str	eet Apt. 4H	_	10f. Zip Code 21202			10g. Citizen o	f What Coun	itry?
900	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Armed Forces? 1 Armed Person 2 No If Yes, Give Year or Dates.		Vas Decedent of Hi f Yes, specify Cuba		oecify Yes or No- o Rican, etc.)		ace - Americ ack, White, e	etc.
Maryland 21215-0036	ithin 72 hou ene. r than "nati the Medica	Completed	15. Decedent's E (Specify only highest gr Elementary/Seconday (0-12) 12th		(Give F life. D	lent's Usual Occupa kind of work done a D NOT use retired) LENANCE		rking	16b. Kind of Balto		
land 2	e should be filed w h and Mental Hygi 7 is marked othe traumatic event, t	To Be	17. Father's Name (First, Middle, Last) Alvin Garthrig	ht Sr.			18. Mother's Name	me (First, Middle, Tyree			
, Mar	nd 2 should lealth and N m 27 is me her trauma	j	19a. Informant's Name/Relationship (1) Jean Sumwalt/ sis	ter	521 Ha	ng Address (Street a			1. 2109	0	
Baltimore,	permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other tra	30	20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State Bays	riew C	sition (Name of natory or other plac rematory	5/26	Date 5/2011	Balto.	Md.	
Ba	permi Depar Impo any ir		21. Signature of Funeral Service Licente	lldridge	100	Name and Addres					P.A.
The same of the sa	Medical Examiner	Examiner	23a. Part 1. Enter the disease, or com shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury)	a. LUNG CANCER Due to (or as a consequence) Due to (or as a consequence)	ence of):	er the mode of dying	g, such as cardiac	c or respiratory ar	rest,		Approximate Interval Between Onset and Death
09/	icate be executed physician and sthe burial-transit	ledical Exal	that initiated events resulting in death) Last	c. Due to (or as a consequent of d.	ence of):			<u>.</u>			
Box 68	death certif ne attending ed for use a	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3 🗌	Ectopic pregnand Other (specify)	sy			Date of delive	ery Day Year
ls, P.O.	v requires that the state of th	<u>م</u>	Part II. Other significant conditions of	contributing to death but not resu	ulting in the u	nderlying cause giv	ven in Part I.				ne cause of death?
Records,	the Hospital or Attendir g Physician. The law requires that the Must A hours airer death. The A hours airer death the Funeral Director: After this certificate has been signed by the professed filled in by the funeral director, page 2 should be detached.	Completed						1 Tes		were autop prior to co death? 1 \(\sum \) Yes	psy findings available mpletion of cause of 2 No
Vita Vita	/sician s certif	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🗶 No	Hospital:	EB/Outpatier	Otho	er:	, , ,	dence 6 K O	her (Specify	HOSPICE
Division of Vital	ttendir g Phys death. stor: Af er this the fureral dir	Certificate: 7	27. Manner of Death 1 M Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	y at	1	now injury occu		
Divis	oital or Attendi ours af er death eral Director: A illed ir by the fi		3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined	building, etc. (Specify,)			City or To	vn, State)		Route Number,
	To the Hospital within 24 hours a To the Funeral C completed filled	Medical	(Check 2 Medical Exam	vsician: To the best of my knowled niner: On the basis of examination rse Practioner: To the best of my	and/or invest	tigation, in my opinic	on, death occurred e time, date and pl	at the time, date	and place, and c	lue to the car manner as st	use(s) and manner stated ated.
	-> - 0		· Affine	2 CANP	93a) /T 5	B14	9792		5/23	2011	
1			-1.07-TD -103770 07	completed cause of death (Item			TIMONIU	M, MD 21	093		
	Sta Registra	te ar	31 Date filed (Month, Day Year)	32 Negistrar's Signat		uke					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 8:58AM Mai ber 2011 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) OG 109 11931 Ita Ø 6. Sex If Under 1 Year Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months 212-28-914 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 es 2 No event, the Medical Examiner must be notified Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 Never Married 2 Married 5-0036 1 ☐ Yes 2 ☐ No Specify <u>Ş</u> 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Saltimore, Maryland 2121 marked other than Elementary/Secondary (0-12) College (1-4or 5+) Â 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٩ Yrown as 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Department of Heal Important: If item 2 any Injury or other Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition c. Location - City or Town, State Pages 1 ₩ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Aurack of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CANCER Immediate Cause (Final **Physician** ROSTATE EAX disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) the detached 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 XN0 1 ☐Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 1 Yes 2 No 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient After this 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? the Hospital or Attending 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Doo1693 25/2011 and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wymen pk DV 3100 21211

DHMH 17 Rev 1/2001

State Registrar

HELDER HAVINDOO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 4:40AM Marie Audrey Hergenhan MAY Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE AGNES N/A HOSP Social Security Number 8. Date of Birth Month, Day Yea NOV 25 If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 🗓 F 89 ^(ear)1921 °Virginia Yrs **Director** 224-24-9980 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 💢 No Lansdowne MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21227 United States 335 Clyde Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles C. Crockett Lillie J. Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 Coastal Walk, St. Mary's, GA 31558 Janet M. Taylor - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 X Cremation 3 - Removal from State May 28,2011 4 Depation 5 Other (Specify) Atlantic Crematory Glen Burnie, MD Signatura of uneral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home, Inc. 2719 Hammonds Fry Rd., Lansdowne, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) BREAST Onset and Death Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, F Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 2 🗷 No Yes Division of Vital 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? lospital: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 20065861 MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 FERRY HAMMONDS State

DHMH 17 Rev 7/2009

Registrar

HER GENHAN,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 6:46 Eva A. Hampton NA 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rehabilitation If Unde If Under 24 Hrs. **Funeral** 8 Date of Birth 9. Birthplace (State or Foreign 1 □ M 2**X** F Months Min. Director Maryland 213-09-9939 92 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified. 10a State 10b. County 10c, City, Town or Location Director 10d. Inside City Limits Balto. Nottingham 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4003 Pinedale Drive 21236 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3

▼ Widowed 4 □ Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Home <u>Homemaker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emelio Scaramozza Blanche Mainolfi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR. 2247 Schuster Road Jarrettsville, Md. 21084 Paula A. Laubach 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5-28-2011 Balto. Md. Lorraine Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Ci. U Nottingham, Md. 21236 9705 Belair Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Exåminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or Tinjury that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death Yes 2 No Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 XNO Hospital: Other: မှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pendina work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mpnth, Day, Year) 056545 25/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 W. MACPHAIL RD #106 BEL AIR HUSLA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mayonth 25, 06:32 A M Theresa L. Hammerbacher 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F May 9, Year 1937 County land Months Davs Hours 74 Director 216-32-3377 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits by Funeral Director 1 Yes 2x X No MD Harford Abingdon 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 4050 Abingin Drive 21009 USA 12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XXIo Specify: White If Yes, Give Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 9 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Leicht Dorothy Ehrline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry Hooker (DTR) 1142 Harford Town Drive, Abingdon, MD 21009 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 St Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/28/2011 Glen Burnie, MD Atlantic Crematory re of Funeral Garden License 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signat 610 W. MacPhail Rd., Bel Air, Maryland 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 8 hours Immediate Cause (Final Acute Anterolateral Myocardial Infarct Physician/ disease or condition Medical resulting in death) Examiner Atherosclerotic Coronary Vascular Disease 4ears Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical pe 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 🗌 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Diabetes Mellitus type II the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 X No Obesity 24a. Was an autopsy performed? Yes 2 \sum No Hypertension 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes Hospital: 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending iniurv 1 Yes 2 No 2 Accident Investigation M 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 🔲 Homicide determined City or Town, State) 24 hours 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b. Signature and title of certifier 29d. Date/signed (Month, Day, Year) 10 Ey Name and address of person who completed cause of death (Item 23a) (Type, Print) Moreira 520 Upper Chesapeake Drive Suite 201 Bel Air, 14021014 Registrar

DHMH 17 Rev 7/2009

ammer bache

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene] Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ WILLIAM HU77MAN 1927 NOC 1 2 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore <u>Good Samaritan Hospital</u> 8. Date of Birth May 27, 1943 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □XM 2 □ F Davs Hours Min. Director 67 Maryland 219-40-3863 Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Dunda1k 1 🗌 Yes 2 ី No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 United States 1902 Rettman Lane 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 XMarried ☐ Yes 2X No 1 ☐ Yes 2 ☐XNo Specify: If Yes, Give Year or Dates. Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing <u>Factory Worker</u> 10 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Evelyn C. Clinton Buford L. Huffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dundalk, Maryland 21222 William Huffman, Jr. 1902 Rettman Lane 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hill Mem. Gdns. 5/28/2011 Middle River, Md. 21. Signature of Funeral Service Lice 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 23 art 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ASCNI Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Exami ohysician and the burial-transit Cause (Disease of finjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 Yes 2 9 Unknown Yes 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Director:** After this certific I in by the funeral director, 26. Place of Death (Check only one) Be Hospital Yes 2 ☐ No Other: မ ER/Outpatient 3 DOA 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. Natural 5 Pending injury 1 Yes 2 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00 (8230 maria 34,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grad Samantan Hotela SHASHLD HARAN 31. Date filed (Month, Day, Year) Registrar

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Edna Grace Hickey Ma_{v}^{Month} 24ay 201°1 12:24 p^M Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Baltimore Charlestown Renaissance Gardens Catonsville 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F Days Min. March Day Yell'922 89 Mar VI and Director 218-22-4848 Usual Residence of Decedent tem 27 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Examiner must be notified at 10a. State should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Md. Baltimore Catonsville 1 🗆 Yes 2 🗖 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 709 Maiden Choice Lne. RGT-229 21228 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 3altimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) cernit. Page 1 and 2 should be filed within 72 Cepartment of Health and Mental Hygiene. Important: If tem 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 10th Telephone Operator Standard 0il Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Edward Hickey Grace Edna Shriver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Hickey/ Nephew 4004 3rd st. Balto Md. 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Dremation 3 Removal from State Bayview Crematory 5/25/2011 4 Donation 5 Other (Specify) Balto. Md. . Signature of Juneral Service 🕮 22. Name and Address of Facility Gonce Funeral Service P.A. 4001 Ritchie Hwy. Balto. Md. 21225 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death
Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown ulcer of Right Ischial Tuberosu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 8 B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geam occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21234 atonsville

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 23 2011 Deborah Hayes May 4:15 A^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Patuxent River Health & Rehab. Ctr Prince George's Laurel Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth (Month, Day, 1 □ M 2 💢 F Days Hours Country) Maryland Months Min Director 217-74-7956 54 June 1956 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medi al Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 Tes 2 No MD Howard Gaorga's Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7151 Beverly Drive #A 21075 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 💢 No Specify: Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) heavy equipment operator construction Be unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Chiafulio/friend 12319 Stonehaven Lane #S-22 Bowie, MD 20715 permit. Page 1 and 2 Department of Health Important: If item 2 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1
Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) A Funeral Service 21. Signatur 32. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street any Director 21201 Baltimore, MD 23a. Part 1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic Breast Cancer disease or condition Months Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) sician and bunial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death ed by the a detached f 1 Yes 2 9 Unknown Yes 2 No 4 ☐ Pregnant 9 ☐ Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Preummie Bilateral Records, Completed 1 Yes 2 No 3 Probably 4XXUnknown Morsid 24b. Were autopsy findings available prior to completion of cause of death? Obesity 24a. Was an autopsy page 2 performed? Yes XX N 2XXNo 1 Yes 25. Was case referred to medical Division of Vital funeral director, Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) 1 Yes 2**X** No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending work? 2 Accident
3 Suicide 2 No Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined e Funeral C Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 [3 [Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 53411 May 23, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14300 Gallant Fox Lane, Suite 210, Bowie, Jagdish Shesadri MD 20715 31. Date filed (Month D 2. Registrar's Sign State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Calvin Milton Jones May 2Ó11 12:28 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's Social Security Number If Under 1 Year **Funeral** Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F Hours 239-13-4654 53 March 17. 1958 North Carolina **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Maryland 1 X Yes 2 No Prince George's Capitol Heights 10e. Street and Number 10q. Citizen of What Country? 5650 Prescott Court 20743 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 X Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 2 X No 1 ☐ Yes 2 X No Specify: Specify: Black "natural", 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) Office Service & Facilities Elementary/Seconday (0-12) College (1-4 or 5+) Manager Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental tem 27 is marked o Page 1 and 2 should be f Walter Jones Mattie Louise Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juanita B. Jones (Wife) 5650 Prescott Ct., Capitol Heights, MD 20743 Important: If item 2 any injury or other i 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗌 Cremation 3 🗔 Removal from State Stoney Creek Cemetery 5-31-2011 4 Donation 5 Other (Specify) Rocky Mount, NC 22. Name and Address of Facility
Hunter-Odom Funeral Home
240 Atlantic Ave., Rocky Mount, NC 27801 Signature of Funeral Service Licensee oben 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ HEART FAILURE CONGESTIVE disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** CARDIOMYOPATH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician by Physician/Medical use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year signed by the at d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? FIBRILLATION 1 Yes 2 No 3 Probably 4 Unknown Completed HYPERTENSION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed Yes 2 death? 1 Yes 25. Was case referred to medical funeral director, Medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 🗆 No Accident
Suicide
Homicide Investigation Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier соmpleted (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0064986 5/26/2011 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

Hilly 31. Date filed (Month, Day, Xear)

P.O. Box 68760 Records, Division of Vital

30

amend item 5 per dyr 2015 1-3 Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 02:47 PM Marcellus L. Jones Henry C. Jones Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore/Washington Hospital Glen Burnie AA 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 214-38-2087 1 SM 2 F Director 68 7/26/42 MD r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director AA MD Pasadena 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7951 Lee Hall Rd 21122 USA hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐xNo If Yes, Give Š Maryland 21215-0036 Specifrican 1 Yes 2 No Specify. 3 Widowed 4 Divorced Completed Year or Dates Amer 15. Decedent's Education permit, Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the Mexicone. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore County Board of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daniel Jones Martha Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth L. Jones/Wife 7951 Lee Hall Rd,Pasadena,MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 5/28/11 Cedar Hill Cem. 22. Name and Address of Facility Hari P. Close F.Svs, PA 21. Signature of Funeral Vervice Liceni 5126 Belair Rd, Balt., MD 21206-5105 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final M4000000010 Physician/ disease or condition resulting in death) Medical Examiner OVUNGVY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and a betached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown Part II. **Other significant conditio**ns contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has 1 Yes 25. Was case referred to redical funeral director, Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or recovery within 24 hours after death.

To the Funeral Director: After this remainded filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide 3 ☐ Suiciae
4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2011 outerfield Rul ste A 31. Date filed (Month, Day, State Registrar VDHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

MAY 14,2011 1116 PANIEL IC JENKINS Baltimore, Maryland 21215-0036

3760	
O. Box 68	
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of Vital Re	
Division	

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		For State		State of M	laryland .		rtment of H		Mental Hy	giene	nii	16969
		Registrar 1. Decedent's Name	e (Eirst Middle	l act)		Cer	tificate of D	<i>Death</i>		Reg. No.	- 0 1 1	
Physicia				h Jenkins					2. Date of Dea Month May 16	Dav	11 Year	3. Time of Death 11:16 A M
Medic Examin				give street and number)			4b. City, Town, or	Location of Death			County of Death	
				entist Hosp	ital		Roc	kville		M	ontgome	ry
Funeral Director		5. Social Security No. 215-06-8	- 1	3. Sex 7. Ag 1 🛣 M 2 ☐ F	je (In yrs. last l	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Day January	th ^y 28 ^{ear)} 1	9. Birti Cou Ma	hplace (State or Foreign intry) iryland
		Usual Residence of	Decedent						Joannary	20, 1	274 118	II y I allu
yland -f sho ed at	ctor	10a. State	10b. County		10c. City, To	own or Loc						10d. Inside City Limits
r 28a notifi	Dire	Maryland 10e. Street and Nun	Montg	omery			Gaith 10f. Zip Code	ersburg		10 011		1 🔀 Yes 2 🗆 No
with the 23a c	Funeral Director	7 Blue R		lourt			208	178			en of What Cou Inited	
eath v	Fune	11. Marital Status	CIDDON C	12. Was Decedent		13. V	/as Decedent of His Yes, specify Cubar		ecify Yes or No-		4. Race - Amer	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Marri		Armed Forces? 1 X Yes 2 If Yes, Give Year or Dates.			Yes, specify Cubar Yes 2 No		HICAN, etc.)	s	Black, White pecify: Wh:	
hours natur lical I	Completed	1900	15. Decedent		1	6a. Deced	ent's Usual Occupa	ation		16b. Kin	d of Business I	ndustry
nin 72 ne. :han "	omg	Elementary/Seco		College (1-4 or	5+)	life. DO	ind of work done do NOT use retired)	unng most of work	ang		lities	
d witl Hygier ther t	Be C	17. Father's Name (I	Eirst Middle Los	2			Manager	40 Mattada Nasa	- /Fire to the distriction		_	College
be file ental I ked o c eve	To E			Jenkins		18. Mother's Nam	ry O'Ne		urname)			
nould ind Mi s mar umat		19a. Informant's Na			1	9b. Mailin	g Address (Street a				own, State, Zip	Code)
id 2 st ealth a n 27 i⊧ er tra	58	Laura E	. Jenki	ns / Wife	-1							land 20878
of He of He If iten		20a. Method of Disp		Removal from State		e of Dispos	sition (Name of atory or other place	e)	Date	20c. Loc	ation - City or	Town, State
. Page tment tant; jury o	1		5 Other (Sp.				Cemetery		20, 2011	Gern	antown	, Maryland
permit Depar Impor any in	23	21. Signature of Fur	A VI	2	.619	R6	bert A. i O West Mon	s of Facility Umphrey Leomerv Av	Funeral	Home	e / Rock e. Marvla	ville, Inc.
		23a. Part 1. Enter to shock, or hear	he disease, or control failure. List only	omplications that cause by one cause on each lin	e.	o not ente	r the mode of dying	g, such as cardiac	or respiratory arr	rest,		Approximate Interval Between
Ph _, sician/	F 7	Immediate Cause (disease or conditio	Final	meto	15tati	ic a	ppendi	iceal co	arcinor	na		Onset and Death
Medical Examiner		resulting in death)	4	Due to (or as	a consequenc		11					
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ted J Insit	Examiner	cause. Enter Under Cause (Disease or i	rlying linjury		a consequence	,0 01/.						
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attending p	Physician/Medic	23b. Was decedent in the past 12 r 1 Yes 2	months?	1 Live Birth 4 Pregnant a	2 Fetal de		Ectopic pregnancy Other (specify)	У		2	3d. Date of deli Month	ivery Day Year
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requires that the de been signed by the should be detached	þ	Part II. Other signifi	icant condition	s contributing to death b	out not resultin	ig in the ur	derlying cause give	en in Part I.				the cause of death?
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or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transi	Completed								24a. Was autor	osy	24b. Were aut- prior to c death?	opsy findings available completion of cause of
sician: The law certificate has b irector, page 2 s		25. Was case referre	ed to medical	-			26 Die	ce of Death (Chec		rmed? 2 No		2 No
ysicia s cert direct	To Be	examiner? 1 Yes 2	_	Hospital:	ent 2 🗆 ER/	Outpatien	Othe	r:	ome 5 Resid	tence 6	Other (Speci	f _V)
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al or At s after o I Direct d in by	Certificate:	4 Homicide	determin			farm, stre	et, factory, office		28f. Location (S City or Tow		Number or Run	al Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director.	Medical	(Check 2	Medical Exa		xamination and	d/or investi	gation, in my opinior	n, death occurred a	t the time, date a	ind place, a	and due to the c	ause(s) and manner stated.
o the vithin of the omple	Š		L Certifying N	urse Practioner: To the	best of my kno	owledge, d	eath occurred at the 29c. License				and manner as s signed (Month)	
		1	廿人		22			635		may	1417	
102h				no completed cause of d	leath (Item 23a	a) (Type, Pr	int) Plai	lip DW	H. (1)	nou		land 20832
01-1		31. Date filed (Month		lan MD	18111	Frir	1111	17 0110	9 01	1109	,	70877
Stat Registra	-	,	Y 3 1 20)11 June	ar's Signature	par	المعا					
		1.11		1	_	-						

Anna A. Jenkins 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Frostburg Village Frostburg
If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 💢 F 84 Director 215-20-7285 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 28a-f show or other traumatic event, the Medical Examiner must be notified at **Funeral Director** Cumberland MD **Allegany** 10e. Street and Number 10f. Zip Code items 23a 135 N. Mechanic Street #1008 21502 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 X No Specify: Completed by 3 ☐ Widowed 4 🔯 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) office manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental h David Earl Thomas Sr Mary Ann Thomas ပ 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once. Bonita Cook/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Puneral Service I consee ROTIA LO S 2 Words Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Immediate Cauce (Final disease or condition resulting in death) **Physician** FAILURIE /Medical Due to (or as a consequence of): Examiner CIRRAUSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Be Completed 25. Was case referred to medical examiner? Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 Natural
2 Accident 5 Pending investigation

6 Could not be determined

3 Suicide

29a. Certifier

Medical

State

4 Homicide

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 135 N. Mechanic Street #1008 Cumberland, MD 21502 20c. Location - City or Town, State 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Approximate Interval Between Onset and Death 23d. Date of delivery Year Month Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number Halle 126907 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harjit S. Sidhu 925 Bishop Walsh RD Cumberland, MD 21502 Registrar's Signatu ORIGINAL

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #30 Per Dyr C915 5/31/2011 JH State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 1. Decedent's Name (First, Middle, Last)

Certificate of Death

2. Date of Death Day May 19,

8. Date of Birth (Month, Day, Year)

Nov 16,

Reg. No.

2011

1926

USA

4c. County of Death

10g. Citizen of What Country?

Race - American Indian, Black, White, etc.

Specify: white

16b. Kind of Business/Industry

Allegany

3. Time of Death 2:55_PM

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐Yes 2☐ No

Maryland

Physician /Medical

To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland Department of Health and Mental Hygiene 23a per dr., g915, 05/31/2011 dnb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Fleming Miriam Johnson Month May 2011 12:40 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2906 Radius Rd. Montgomery Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Days | Hours | Min. | (Month Day Year)
April 19,1919 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral 9. Birthplace (State or Foreign 1 ☐ M 2**X**XF 92 South Dakota Director Vre 501-14-7432 Usual Residence of Decedent 28a-f shov 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 Ves 2 No 6 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 2906 Radius Rd. 20902 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes XX No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 XWidowed 4 ☐ Divorced Completed Specify. White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Secretary Federal Government other traumatic event, Be 17. Father's Name (First, Middle, Last permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or our 18. Mother's Name (First, Middle, Maiden Surname) ည Fleming William Henry Elizabeth Anne Rehberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurence F. Johnson / 6004 Henning St., Bethesda, MD 20817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) Uniformed Sers. Univ: 05/09/2011 Bethesda, MD Name and Address of Eacility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition ADULT FAILURE TO THRIVE Medical resulting in death) Due to (or as a consequence of Examiner Debility Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami -transit executed resulting in death) Last Due to (or as a consequence of): burial physician s the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Pregnant at time of death Yes 2X No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No page 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2XXNo Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home XX Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. Investigation 6 Could not be completed filled in by the Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) May 6, 2011 D37142

Registrar
DHMH 17 Rev 7/2009

State

1355 Piccard Dr. #100, Rockville, MD

20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3% Registrar's Signa

Georffrey Coleman M.D.

31. Date filed (Mont

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year 11:23 PM e1500 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 302 altimore altimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State of ial Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X Months Country) 9 Director 13 Usual Residence of Decedent "natural", or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 K Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21231 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3- Widowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) MAC 8+1 Be 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) ပ္ Kritz ACOB 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other pla eterms 4 Donation 5 Other (Specify) ZUI Signature of Juneral Solice in ensee 5 23a. Part 1. Enter the sease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart ailure. st only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ advanced Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 Y No
9 Unknown Month Day Year 4 Pregnant a Pregnant at time of death 5 Other (specify) Be Completed by

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 io the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 124 hours after death. e Funeral Director: After this certificate has been

	major depressive disorder	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown							
		24a. Was an autopsy performed? 1 ☐ Yes 2 ☒No 1 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No							
25. Was case referred to medical	26. Place of Death (Check only one)								
examiner? 1 Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 M Residence 6 ☐ Other (Specify)								
27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigati		28d. Describe how injury occurred							
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	1 28e Place of Injury - At home tarm street factory office	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	ysician: To the best of my knowledge, death occured at the time, date and place, a niner: On the basis of examination and/or investigation, in my opinion, death occurred								

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year, 201

State Registrar

Certificate: To

Medical

only one

29b. Signature and title of certifier

Holder

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

within 2

ORIGINAL

32. Registrar's Signature

11-03822	
Eric Kelly	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Imend ** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day May 21, 2011 1635 hrs Medical Examiner Eric Dwayne Kelly
4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2706 East Preston Street N/A 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5 Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Days Months Hours Min Director 1X M 2 F 45 44 Country) 0/22/1966 C 77-56-6749 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits IDA 10a, State 10b. County 1 X Yes 2 No show N/A Baltimore Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2706 E. Preston Street USA 21213 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 8lack, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No 1 Yes If Yes, Give Year or Dates: 1 Yes 2 X No specify: 4 X Divorced 3 Widowed Black ò 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 N/A yrs. Unemployed 12th 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Margie Chambers Marcel Coates Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6311 Lynus Dr. Baltimore, MD 21207 19a, Informant's Name/Relationship (Type, Print) ို Marcel Coates-Father 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a, Method of Disposition crematory or other place)
King Memori 1 X Burial 2 Cremation 3 Removal from State 5/28/2011Randallstown, Memorial Pk. 4 Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Euperal Service Licenses March F/H 1101 Ε. North Balto., MD21202 Ave. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Retween Onset and /Medical Immediate Cause (Final disease a. Narcotic (Methadone and morphine) Intoxication and cocaine use Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to inspectate Dire to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical AMENDED 23a, 27, 28a-f 19b per fh g signed by the attending physician a be detached for use as the burial -X UNPENDED -f per me ig 916 6-6-11 smDivision of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed this certificate has been I director, page 2 should 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 2 No Yes 2 No 1 🗸 Yes Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗸 Other; Scene ER/Outpatient 3 DOA 1 Yes 2 No After t 28c. Injury at Work? 28d. Describe how injury осситеd 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death cation: 1 Natural 1 Yes 2 X No 5 Pending fd 4:00 pm 24 hours after death. fd 5-21-11 Director: the 2 Accident in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 3 Suicide or Town, State) 2706 E. Preston St. Baltimore, Md. determined (Specify) 4 Found at Residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Che one) Medical within 2 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the] nd manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. May 22, 2011 30. Name and address of person who completed cause of death (Item 23a) OCME Mary G. Ripple MD Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

car's Signature

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar

31. Date filed (Month, Day, Hear)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		For Stete Registrar	State of Maryla	-	rtificate of De		Reg	4011	169/4
Physicia /Medic		Decedent's Name (First, Middle, Last) Eleanor		d			Date of Death Month	Day Year	3. Time of Death 3.10 PM
Examin		4a. Facility Name (If not institution, give Roland Park Place 5. Social Security Number 6. Sec	street and number)	. last birthday	4b. City, Town, or Lo		Date of Birth	4c. County of Death	
Funeral Director			M 20XF 76	Yrs.		Hours Min.	Date of Birth (Month, Day, Y Sept 4,	1934 Ir	nplace (State or Foreign untry) eland
with the Maryland a or 28a-f show Lbe nutified at	tor	10a. State 10b. County MD • N/A		ity, Town or L altimo:					10d. Inside City Limits 1 X Yes 2 ☐ No
n with the 3a or 28a st be nuti	ai Direc	10e. Street and Number 830 W. 40th St.			10f. Zip Code 21211		10g	. Citizen of What Co USA	
rious allel beatti with the mayna tural', or Itama 23a or 28a-f show al Examiner must be nutified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🎗 Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 ※ No	anic Origin? (Specif Mexican, Puerto Ric Specify:	y Yes or No- can, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
uppartment or featin and wantar tygens. Important: If item 27 is marked other than "ratural; any injury or other traumatic event, the Medical Exa once.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	edent's Usual Occupation se kind of work done dur DO NOT use retired) maker	on ing most of working		b. Kind of Business/ Dwn Home	Industry
kad othar t ic evant, ID	To Be Co	17. Father's Name (First, Middle, Last) Joseph McCandle		Tionic		8. Mother's Name (F			
r traumati	ř	19a. Informant's Name/Relationship (Ty Andrew Kidd/ Son			ing Address (Street and	d Number or Rural R			Zip Code)
nt: If itam ry or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from State	Place of Disp cemetery, cre	osition (Name of or other place) Service Co	Date	e 20	oc. Location - City or Γ owson $_{f lpha}$ ${ m MI}$	
Importa any inju once.		21. Signature of Theral Service Licens	A	2	2. Name and Address Ruck	of Facility Towson Fu	neral Ho	ome, Inc. MD. 21204	
edical aminer transit	dical Examiner	Immediate Causa (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect. Due to (or as a consect. Due to (or as a consect.	equence of):	menta				Onset and Death
led by the attending posterior of detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	ivery Day Year
6 8		Part II. Other significant conditions co	ntributing to death but not re	esulting in the	underlying cause given	in Part I.	23e. Did tobacco use contribute to the cause of de		
cate has been si page 2 should	Completed						24a. Was an autopsy performe	prior to	utopsy findings availabl completion of cause of 2 No
n, After this certificati funeral director, pe	on: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Mann of Death 1 ✓ Natural 5 ☐ Pending	Hospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatie	ent 3 DOA Other		5 ☐ Residen	oce 6 □Other (Spe v injury occurred	ocify)
<u></u> e	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Special Control of the C	home, farm, s		s 2 □No	f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
To the Funeral Directo completely filled in by the	Medicai C		rsician: To the best of my k iner: On the basis of exami- and manner stated.						
o th	Me	29b. Signature and title of certifier	A August	7 2	29c. License	number 657		d. Date signed (Mon.	
within 2 To tha complei		> 77 Babille 1 7ª	the pregner	19	013	621	1.6	any of 11 h	9 (1

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 22 Day 20[°]fa' 10:32 a.M Dorsey Magnus Kline Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Timonium Baltimore Stella Maris 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗶 M 2 🗆 F Months Days Hours Min. Sept. 23, Yrs. Maryland 1930 Director 80 213-26-1612 Usual Residence of Decede 28a-f show 10a State 10b. County ral", or items 23a or 28a-f shorexaminer must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Dunda1k Maryland Baltimore 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 United States 8008 Wallace Road 12. Was Decedent Ever in U.S. Armed Forces? ★★ Yes 2 □ No if Yes, Give Year or Dates. **Korea** Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", 3 Widowed 4 Divorced Completed White permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) #16 - Iron Worker Manufacturing 8 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 2011 Elizabeth Dorsey Magnus Maxwell Kline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8008 Wallace Road Dundalk, Maryland 21222 Rose M. Kline (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 🛱 Burial 2 🗆 Cremation 3 🗆 Removal from State Donation 5 Other (Specify) 5/27/2011 Baltimore, Maryland 0ak Lawn Cemetery 21. Signature of Funeral Service Licens 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part 1. Enter the of shock, or heart falls sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Phyllician/ CONGESTIVE HEART FAILURE disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events Due to (or as a consequence of) Examin Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tranresulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 1 Yes 2 L 9 Unknown 9 Unknown Division of Vital Records, P.O. DORSEY KLINE Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 XNo 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 page, performed? Yes 2 No certificate 2 🗆 No 1 🗌 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 2 **X** No 1 🗌 Yes မ ER/Outpatient 3 DOA 1 Inpatient 2 I 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) 5 Pending thin 24 hours after death.

the Funeral Director: Af
mpleted filled in by the fu 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of 23/2011 person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar 31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May 19 2011 Essie Pearl Karis 5:50 a.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 2075 Jasmine Road Social Security Number 6. Sex Dunda1k If Under 1 Year 8. Date of Birth (Month, Day, Sept. **Funeral** 7. Age (In vrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F Months Days Virginia **Director** 85 227-28-7610 1925 Usual Residence of Decedent 28a-f show 10a, State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🙀 No Baltimore Dunda1k <u>Maryland</u> 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r Funeral <u>2075 Jasmine Road</u> United States within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 nan "natural", Medical Exan 1 ☐ Yes 2 X No Specify Specify: White Completed 3 X Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry The filed within all Hygiene.
Ther than "n.
The Me "t, the Me" (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 vears Own Home Homemaker traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental Fortems of Health and Mental Fortems 27 is marked o ပ Warner Lee Shiflett Blanch M. Shiflett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Dowden (Daughter) 2075 Jasmine Road Dundalk, Maryland 21222 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 0 Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place. 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Serv. Corp. May 21, 201 Towson, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Avenue Dundalk, Maryland 21222 21. Signature of Funeral Service Licensee eart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Ph sician Congestive Heart Failure Medical Years Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury and tran that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day the 9 Unknown ģ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. signed d be det 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 XNo Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 TResidence 6 Other (Specify, 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) Certificate: 28d. Describe how injury occurred eral Director: After filled in by the funer 1 XNatural 5 Pending Accident Suicide Investigation 3 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined within 24 hours a

To the Funeral C

completed filled Hospital Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 5-19-11 D0018951 30. Name and address of person who completed dause of death (Item 23a) (Type, Print) Reza Sajadi. 1005 North Point Blvd. Baltimore, Maryland 21224 M

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene dr., 2513,05/31/2011 dnb Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2011 11:52 P M Margaret Lynn May 6, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ft. Washington Medical Center Ft. Washington Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye July 13, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year! Months Days 1□ M 2□√F Yrs. 423-38-5505 Director 80 1930 Alabama Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 🕅 No Director Maryland | Prince George's Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1903 Dania Drive 20744 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ሺ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Black <u>6</u> 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 Elementary/Secondary (0-12) College (1-4or 5+) Operator Vending Machines 12 Pages 1 and 2 should be filed vent of Health and Mental Hyginnt: If item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Washington Thomas Leona Williams traumatic ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3393 E. 149th St., Cleveland, OH 44120 Gail Berry (Daughter) Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Important: f any Injury o Cleveland Mem. Gardens 5/17/2011 Cleveland, OH 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility E.F. Boyd & Son Funeral Home 2165 E. 89th St., Cleveland, OH 441<u>06</u> 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** perteusion disease or condition resulting in death) /Medical Due to (r as a consequence of) Examiner gocardial (Near two POST Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 D Ectopic pregnancy in the past 12 months? Month signed by the a 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown s peen s Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? this certificate 2 No 1 □ Yes Vital Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To ö funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900) tasts SINNO

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 26, 2011 8:00 а м Theodora Lewandowski Α. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery Arden Courts Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 30, Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Days Hours Year) 21 Yrs **Director** 186-16-8311 89 Pennsylvania Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland items 23a or 28a-f sho ner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director NJ Middlesex Edison 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20 Parker Road 08820 USA · death v 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify White "natural", Specify Completed 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumation. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Managerial Secretary Hotel/Motel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Agnes Schap Ignatz Karpinski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4607 Beechwood Rd., College Park, Maryland Gary Lewandowski - Son 20740 20b. Place of Disposition (Name of cemetery, crematory or other place)
Woodbridge
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Buylal 2 Cremation 3 Removal from State 4 Departion 5 X Other (Specify Entombment 6/7/2011 Woodbridge, NJ 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kowalski Funeral Home 515 Roselle Street, Linden, NJ 07036 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final h, sician Failure to thrive disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Hypertension Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Hyperthyroidism and that initiated events Due to (or as a consequence of) resulting in death) Last burial physician the burial Physician/Medical Hyperlipidemia Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🏝 No 5 Other (specify) Month Dav Year Pregnant at time of death the g Unknown g Unknown signed by to detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Gastroesophageal Reflux Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖺 Unknown 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page performed? Yes 2 No certificate ! 1 Yes 2 No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital Other: 2X X No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4

✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at w<u>ork</u>? 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending iniury after death. Accident 1 Yes 2 No М Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours Medical 29a. Certifier 1🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D20274 May 26, 2011 55M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20817 MD 7710 Bradbury Blvd., Kirti Vohra, Bethesda, MD

State Registrar 31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #16b Per FH G915 5/31/2011 III State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year Jarryl Medical May 7:00 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University at Maryland Medic If Under 1 Year If Under 24 Hrs. 8. Date of Birth
June 5, 1945 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 202-36-7111 65 Pennsylvania **Director** Yrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Infmoortant: If tiene Z7 is amarked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore YYYYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 864 Washington Blvd. U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, rmed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes XX No Specify: 3 Widowed WillDivorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working should be filed within 72 hand Mental Hygiene.
7 is marked other than "r life. DO NOT use retired) Restaurant College (1-4 or 5+) Elementary/Seconday (0-12) 4 Maitre'd Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Arthur H. Lutz Sara Mae Winter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas P. Peura / Partner 864 Washington Blvd. Baltimore, MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery cremitory or other place)
AII Faiths
ematory & Chapel 1 ☐ Burial 2XX remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/1/11 Manchester, MD 21. Signature of A Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 1605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate €ause (Final disease or condition Onset and Death Physician/ a. Due to (or as a consequence of) INTER Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or lingury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death the 1 ☐ Yes ∠ ■ 9 ☐ Unknown Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was an autopsy performed? cate has l page 2 s this certificate 2 🗌 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 5 Pending 1 Natural work? 1 ☐ Yes within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I 3 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P25551 05/26/2011 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Short Briann Bultimore S. Greene 31. Date filed (Month, Day, Year) 2. Registrar's Signature State MAY 31 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20¹1 7:45A Patricia Lou Leese May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Carroll Carroll Westminster Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Months Days Hours 09/07/1941 **Director** 218-38-4337 69 MD Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 Yes 2 🗆 No Westminster Carroll MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21157 USA 44 Carroll St. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian the Medical Examiner Armed Forces?
1 ☐ Yes 2 🗷 No Black, White, etc. by 1 Never Married 2 Married ò Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Transportation Bus Driver Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Alice Millicent Thomas Harold Bruce Shatzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains Carroll St., Westminster, MD 21157 Harold Leese Sr.-Husband 44 Baltimore, 20a. Method of Disposition

1 Disposition 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1; cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 6/2/2011 Finksburg, MD Evergreen Signature of Fuperal Service Licer 22. Name and Address of Facility Fletcher Funeral Home framay Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or s a consequence of): Onset and Death Immediate Cause (Final Phisician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of) burial-transit signed by the attending physician and the detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month's? Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 KUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 🗌 No 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 400 Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 \square Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Box 68760 Division of Vital Records, To the Funeral Director; After this certifics completed filled in by the funeral director, I within 24 hours a Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check commed at the time, data and place, and due to the Certifying Nurse Practioner. To the best of my knowledge cleath 29b. Signature and title of certifier SYYSUTG 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sou Day, Year, State 3 1 2011 Registrar DHMH 17 Rev 7/2009 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May Month Day 26. 2011 1:10 Рм Albert J. Leitschuh, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Towson Baltimore 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** X M 2 D F Months Days Hours Min 217-09-0437 91 °1′920 Director Apr. Usual Residence of Decedent 28a-f shov 10a. State 10b. County notified at 10c. City. Town or Location Director 10d. Inside City Limits 1 Tes 2 No MD Baltimore Baltimore 10e. Street and Numbe 10f. Zip Code ò 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 3905 Darleigh Road #2F 21236 USA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, rmed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 💥 No Specify: If Yes, Give Year or Dates 3X Widowed 4 □ Divorced Specify. Completed white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Martin Marietta Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Florian Leitschuh Clara Schendler permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) daughter | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda G. Leitschuh -in-law |21 Kitzbuhel Road; Parkton, MD 21120 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem Gardens: 6/1/2011 Timonium, MD 21. Signature of Fun-22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Fracture disease or condition resulting in death) Medical Due to or as a consequence of **Examiner** Sequentially list conditions. Examine if any, leading to miniediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 as t IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? ģ Pregnant at time of death Month Day Year detached 1 ☐ Yes ∠ ∟ 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 2 No 3 Probably 4 Unknown 1 Tes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed?

Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital: 2 🗌 No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28d. Describe how injury occurred Knocked to grown Truck Struck Shopping Cart Certificate: 28c. Injury at 5 Pending □ Natural within 24 hours after death.

To the Funeral Director: At completed filled in by the fu MARCH 4, 2011 1 Tes 2 Accident UnKhiwm Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) 8647 Bel Arr Rd - Perry Hall, MO 2123 Darking Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis or examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) no title of certifier 29b. Signatur 262011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar USTALLES

M

32. Registrar's Signature

AMON

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5:12 PM elores Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Balti Baltimore Haspital MOTE NA Funeral Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birting MD 1 □ M 2 🗓 F Hours 09-10-44 212-44-2290 66 **Director** Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director must be notified MD NA Baltimore Yes 2 No ŏ 10e. Street and Number 10f. Zip Code 21216 10g. Citizen of What Country? USA 23a Funeral 1221 Poplar Grove Street within 72 hours after death with items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ⚠ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etcAfrican Examiner "natural", or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: American Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 12th Grade the Machine Operator Proctor & Gamble Be iled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnam Williams ပ James Pearsall Elizabeth permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207Cheryl Hawkins-Daughter 34 Greenbury Court Gwynn Oak, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Removal from State crematory or other place) Woodlawn 05-31-11 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) 1 Der Carsic Medical Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner arette or Attending Physician: The law requires that the death certificate be executed as the burial-transit Cause (Disease or iinjury 5m 0 Ki and that initiated events resulting in death) Last attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month signed by the a Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed Yes been : 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼ No 24a. Was an has autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1) Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 Yes 2 No 27. Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 66108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Simmons 7000 W. 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ May 22, Day 2011 Year 6:03 P M Jerome Martin Lease Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5225 Pooks Hill Road Apt #1815S Montgomery Bethesda Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, August 5, **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 X M 2 □ F Days Year) 19<u>50</u> Washington, D.C Director 220-58-9934 Yrs 60 Usual Residence of Decedent ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10h County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 🗌 Yes 2 🏻 No Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5225 Pooks Hill Road Apt #1815S 20814 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1

Yes 2 □ No Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Hygiene. other than "natural", If Yes, Give 1970–1973 Year or Dates. Specify: White 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life DO NOT use retired United States Elementary/Seconday (0-12) College (1-4 or 5+) Mail Classification Specialist Postal Service and Mental Hygie Is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Philip Lease Martha Duda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a 670 Barneson Avenue, San Mateo, California 94402 Katy Lease Lonergan / Daughter permit. Page 1 and ; Department of Healt Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. May 25, 2011 Bethesda, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, M01619 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Sunghoi disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and -transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician s the burial Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Year 2 No 4 ☐ Pregnant 9 ☐ Unknown detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown the been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖔 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No this certificate 1 Yes 2 No or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at s after death. I Director: After t 28d. Describe how injury occurred 1 Natural 5 Pending Self-inflicted gums UnkM may 22 2011 1 ☐ Yes 2 🗶 No Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Peral Rule) City or Town, State) 52 25 completed filled in by 4 Homicide determined Home To the Hospital o within 24 hours af To the Funeral Di 20814 Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) nature and title of certified ~ mo DME 204 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mo DME BRECHEX 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

3 1 2011

Box 68760

Division of Vital

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Ma	2 sho Ith and 27 is r traur		19a. Informant's Name/Relationship (Type Ricky Mayne- So		19	b. Mailin	g Address (Street a Wavbur	and Number or Rura n Rd Ros	il Route Numbe sedale	r, City or Tow. MD	n, State, Zip	Code) 7
e,	1 and of Hea item		20a. Method of Disposition		20b. Place	of Dispos	sition (Name of	!	Date		ion - City or	
<u>m</u>	Page nent c ant: If ury or		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Garde	ery, crem n O	atory or other plac f Faith	6/1,	/2011	Balt	imor	e, MD
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e	1	21. Signature of Funeral Service License	ee u//	3		Name and Addres	11(arch F	/H 11	Ol E	. North
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	To the within 2 To the comple	ž	29b. Signature and Litle of pertifier	e Practioner: To the b	est of my knov	vledge, de	eath occurred at the 29c. License	time, date and place	e, and due to the	e cause(s) and 29d. Date sig	manner as	stated.
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1			30. Name and address of person who co	ompleted cause of de	ath (Item 23a)	(Type, Pr			B - 11			0 21204
7	Stat	0	31. Date filed (Month, Day, Year)	4 6701	Signature -	ull	Dr. 201	16 4107	DAIL	nucl	< 1421	D 91704
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May 23^y 2011 7:10 a. Richard Webster McJilton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore 7260 Meadow Lane Dunda1k 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Hours Min. Mary land Director 82 <u>216-24-1004</u> 1928 Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location notified at 10d. Inside City Limits Director Maryland Baltimore Dundalk 28a-f 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 7260 Meadow Lane 21222 United States death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces'

1 X Yes 2 If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married ģ 2 No within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: 3 Divorced 4 Divorced Completed White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Insurance Agent-</u>Nationwide Insurance traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ပ Samuel Walter McJilton Augusta Virginia Webster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria K. McJilton (Wife) Dundalk, Maryland 21222 of Health 7260 Meadow Lane 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State ō Department of Important: If any injury or once, 4 Donation 5 X Other (Specify) Entombren Baltimore, Maryland May 26, 2011 0ak Lawn Cemetery 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Henatocellular carcinoma Medical Due to (or as a consequence of) Examiner hosis cryptogeni Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examir as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical requires that the death certificate be P.O. Box 68760 IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has performe death? s after death.

Director: After this certificate 2 🗌 No 1 Yes Yes 2 X No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 KResidence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) 5 Pending Μ ☐ Accident Investigation filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) forms formily. My DOU 64193 5/23/11 21205 218 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROSS

DHMH 17 Rev 7/2009

State Registrar JAMES

31. Date filed (Month; Day, Year)

HAMILTON

JOHNS HOPKINS HOSPITAL.

AU5

720 RUTLAND

MD

BALTIMURE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 27 Pay Physician/ May Month 20ÎÎ Barbara Frank Miles 3:15 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Hospice Casey House Montgomery Rockville If Under Social Security Number Age (In yrs, last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, April 4 Hours Min 219-36-8448 71 940 Washington, D.C Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits with the Maryland Director notified Maryland Montgomery Gaithersburg 1 ☐ Yes 2 🎇 No 10f. Zip Code 10e, Street and Number 10g, Citizen of What Country? ò ms 23a or must be r Funeral 20878 United States 217 Firehouse Lane iral", or items? death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or is any injury or other traumatic event. the Market þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Realtor Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Beverly Ρ. Fox Walter Miles, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5047 Greenstreak Drive, Riverton, Utah 84096 Jeffrey Laurier Bedard/Nephew 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Montgomery Crematorium, Inc. May 31, 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland Robert A. Tumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Signature of Fun a Se M01305 Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or fleart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Sarcoma disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last executed burial-tran Due to (or as a consequence of) physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as t attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? for Month Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 🗌 No 1 Yes 25. Was case referred to medical director, 26. Place of Death (Check only one) Certificate: To Be examiner? Assisted Living 2 🗶 No Other: 4 Nursing Home 5 Residence 6 Tother (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA After this funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 5 \square Pending after death. 1 Yes 2 No Accident Investigation the Suicide 6 🗆 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours Funeral leted filled Medical 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 within 2

To the I

complete Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) D0060634 May 27, 2011

304

State

Joseph 31. Date filed (Month, Day,

Registrar
DHMH 17 Rev 7/2009

Joseph C. Bindu, M.D. 6001 Muncaster Mill Road, Rockville, Maryland 20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 2011

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Theodore Reign Marshall	State of Maryland / Department of Health and Mental Hygiene	2011	1598
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		1- For State Registrar	,	Certific	ate of De	eath		Re	g. No.	1 3 2 0 7
Physic		Decedent's Name (First, Midd	lle,Last)					Date of Death Month	h	3. Time of Death
Medical Exam	iner		ign Marshall					May 4, 201	Day Year I1	1840 hrs
7		4a. Facility Name (if not instituti					ocation of Death		4c. County of Dea	
		1101 Middleway Roa				iddle River	Twin in an	To a constant	Baltimore Co	
Funeral Director		5. Social Security Number		yrs, last bir		Under 1 Year onths Days	If Under 24Hrs Hours Min		h(MM/DD/YYYY) 9. B Fore	ign
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Maryland 28a-f show 1 at once	cto	10e. Street and Number	ICIMOTE		Middle	. Zip Code		110	g. Citizen of What Co	11
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rr death with the Maryland or items 23a or 28a-f sho . must be notified at once.		11. Marital Status	12. Was Decedent Eve	r in II S	13 Was Dec			ecify Yes or No-		erican Indian, Black,
eath v items	Funeral	1 X Never Married 2 N	arried Armed Forces?				Mexican, Puerto		White, etc.	filean indian, black,
fter d !", or		3 Widowed 4 Div	1 X Yes 2 vorced If Yes, Give Yeer 1	47-50	1 Yes	2 X No	specify:		Specify: wh	ite
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	d by	15. Decedent's Education (Spe	ecify only highest grade complet	ed) 16a.			n (Give kind of v		16b. Kind of Business	
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Baltimore, permit. Pages I an Department of Hea Important: If iter		4 Donation & X Other S	oecify: in state		22 Name	and Address o	of Eacility	655.33		
Deprin		21. Signature of Funeral Service	wade, lirec	tor			-		Baltimore	Street
Physician		23a. Par I. Enter the disease, or	complications that caused the	death. Do no	t enter the mo	de of dying, su	ID 2120 uch as cardiac o	respiratory arres	st, shock, or heart	Approximate Interval
/Medical		failure List only one cause Immediate Cause (Final disease	Athanandanatia Car	diovascu	lar Disease					Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a conseque							
		Sequentially list conditions,	b							
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" . <u>#</u>	Хан	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	nce of):						
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be ex	Medical	UNPENDED	AMENDED							
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ox 687 eath certific attending	ciar	past 12 months?	1 Live birth 4 Pregnant at time	of death 5		-	Ectopic pregna	ncy	Month	Day Year
Records, P.O. Box 68 The law requires that the death certif cate has been signed by the attending page 2 should be detached for use as	Physician	1 Yes 2 No 9 Uni	9 Unknown		Other to	Specify)				
P.O. es that the igned by t		Part II, Other significant condit	ions contributing to death but	not resulting	g in the underly	ying cause give	en in Part 1.	23e. Did tob	acco use contribute to	the cause of death?
ords, P.C w requires that is been signed by	d by							1 Yes	2 No 3 Pro	bably 4 Unknown
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of Vital g Physician: fler this certifi neral director,	To B	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient	2 ER/O	utpatient 3	DOA Ot	ther ₄ Nursing	Home 5 R	Residence 6 🗸 Othe	er: Scene
ing Ph After After		27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b.	Time of Injury	28c. Injury	at Work?	28d. Describe ho	w injury occurred	
ion ttendi death.	랿	1 Natural 5 Pend 2 Accident Inves	ting stigation			1 Yes	s 2 No			
Division of Vital Records, talor Attending Physician: The law requirers after death. **I Director: After this certificate has been sited in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Coul	d not be 28e. Place of Injury	At home, fa	rm, street, fact	ory, office buil	ding, etc.	28f. Location (Str or Town, Sta		ural Route Number, City
Spital	9	4 Homicide	mined (Specify)							
Division of Vi To the Hospital or Attending Physi within 24 hours after death. To the Funoral Director: After this completely filled in by the funeral dir	Medical	(Check only Certifying Pi	nysician: To the best of my knominer:On the basis of examinat	wledge, dea tion and/or in	ith occurred at ovestigation, in	the time, date my opinion, d	and place, and leath occurred a	due to the cause the time, date ar	(s) and manner as sta nd place, and due to t	ted. ne cause(s)
To Wi	₩.	29b Signature and title of certific	and manner stated.	284	2	29c, License n	number		29d. Date signed (Mo	onth, Day, Year)
		Cuth Il	the steeth	180		O.C.M.	E.		May 5, 2011	
_	<u> </u>	30. Name and address of person			l					
		Victor Weedn MD JD	Assistant Medical Ex				eet, Baltimoi	e, MD 21223	3	
St Regist	_	31. Date filed (Month, Day Year)	2011 Security Si	gnature	back	1				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 03) Physician/ A-55E Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 417 Townsend Ave. . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗡 F Jan 11, Year 920 Days Hours Director 218-01-0627 83 Maryland Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "hother" any injury or other than "hother". 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md. Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 417 Townsend Ave. 21225 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Clerica1 District Court Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stanley Pulc Balych 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thaddeus Kaniewski/son 501 Townsend Ave. Baltimore Md. 21225 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem Park 5/27/2011 Glen Burnie Md. 22. Name and Address of Facility Gonce Funeral Service P.A. Balto, Md. 23a. Part 1. Enter the disease, or complications that causeoune death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death "hysician/ disease or condition / Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or limply that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year Yes 2 No the 9 Unknown 9 Unknown signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 No 3 Probably 4 Unknown peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Director: After that in by the funeral 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours af
To the Funeral Di
completed filled in Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day, Year) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month MAY BETSY G 20^{rear} MERZ 22 6:55 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6313 LA GRANGE LANE BALTIMORE BALTIMORE **Funeral** . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 🗆 M 2 🛣 Months Days Hours 05/26/1933 Director 220-46-7590 MD Usual Residence of Decedent or 28a-f show e notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Tes 2 No BALTIMORE MD BALTIMORE 10e. Street and Number ms 23a or must be r 10f. Zip Code 10g. Citizen of What Country? Funeral 6313 LA GRANGE LANE 21212 ural", or items? USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. d Mental Hygiene. marked other than "natural", 3 X Widowed 4 Divorced Specify WHITE other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) REALTOR REAL ESTATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, 2 MOSES **GELLMAN** FLORA GRANT and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a RICHARD ROSENBLOOM/SON 15 RUXLEA COURT, TOWSON, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of I-Important: If ite any injury or ot 20c. Location - City or Town, State ARLINGTON CHIZUK AMUNO CEMETERY 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 05/24/2011 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Dinereated neural reserving metostatio disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and I-tran Due to (or as a consequence of): attending physician attending the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Dav Year 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ encephalopathi 1 Yes 2 No 3 Probably 4 Unknown Completed Thrombos 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy IVOV tailune perform Yes 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 X No Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) eral Director; After thi filled in by the funeral Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural (Month, Day, Year) injury 5 Pending 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hou

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completed fi 29a. Certifie (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Type, Print) DR. SUITE 302 TOWSON U

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State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month May 25, 2011 Year 7:50 P M Elsie T. Mayer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Columbia Howard Gilchrist Hospice of Howard County If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth **Funeral** (Month, Day, Year)
Dec 3, 1922 Days Min. 1 🗆 M 2 🗶 F MD 88 220-14-6109 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location 10a. State at Director ed other than "natural", or items 23a or 28a-f slevent, the Medical Examiner must be notified **Ellicott City** Howard MD 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21042 U.S.A. 3705 Folly Quarter Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural". or any injury or other trainment. þ 1 Never Married 2 Married Yes, Give 2 No 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates. WWII Eros 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Emma H. Heedy ೭ Franklin H. Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Sharp Rd. Denton, MD 21629 Nancy Minahan daugghter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of metery, crematory or other place)

Lakeview Memorial Park 1 Burial 2 Cremation 3 Removal from State Jun 01, 2011 Sykesville, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 ature of Funeral Servic Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ END RENAL DISEASE MONTHS disease or condition Medical resulting in death) Due to (or as a consequenc 4 Examiner sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year be detached for Pregnant at time of death 5 Other (specify) q Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown ATRIAL FIBRILLATION Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an PERIPHERAL VASCULAR DISEASE has autopsy perform after death.

Director: After this certificate 1 Yes 2 No Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tyes မ 1 Natural 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: injury 5 \square Pending 1 ☐ Yes 2 ☐ No Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital within 24 hours a Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 064395 MAY 26, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6336 CEDAR LANE COLUMBIA, MD 21044 DANIENE DOBERMAN, MO

DHMH 17 Rev 7/2009

Registrar

State

31. Date filed (Month, Day, Year)

parks

32. Register's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

			1 - State of Mai State Registrar	-	Department <i>Certificate</i>				giene Reg. No.	2011	16991
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath		3. Time of Death
	Medic Examin		Barbara Thatcher Nittolo 4a. Facility Name (if not institution, give street and number)		4b. City. To	own, or Location		May	2 ^D a	County of Dea	
مريد	,		Fairland Rehab. and Nursing	Center		Silver Spring				ontgome	
	Funeral Director		157-14-1567 1□M2 KX F	In yrs. last birth	Months	Year If Undo Days Hours	er 24 Hrs. Min.	8. Date of Birt (Month, Day Aug • 5	h 1920	g. Bir Co	rthplace (State or Foreign ountry) NJ
	and Show	ě	Usual Residence of Decedent 10a. State 10b. County 1	10c. City, Town	or Location						10d. Inside City Limits
	Maryla 28a-f	irect	MD Prince George	Laurel							1 🔀 Yes 2 □ No
	h the	alDi	10e. Street and Number		10f. Zip (Code			10g. Citi	zen of What Co	ountry?
	ath wit	Funeral Director	7223 Carriage Hill Drive 11. Marital Status 12. Was Decedent Eve	ar in II S	2070		Vrigin? (Pnor	oif. Ves er Ne	USA		
920	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ğ	1 Never Married 2 Married Armed Forces? 1 Yes 2 Note of the state of t	5	If Yes, specify	y Cuban, Mexic	an, Puerto F	Rican, etc.)		14. Race - Ame Black, Whit Specify: Wh	e, etc.
2-0	2 hou "natu edical	plet	15. Decedent's Education (Specify only highest grade completed)		Decedent's Usual (Give kind of work		ost of workin	na l	16b. Kii	nd of Business	Industry
72	ithin 7 ene. r than	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)		life. DO NOT use r			Medi	ical		
מַ	filed wall Hygard of the vent,	Be	17. Father's Name (First, Middle, Last)			18. Mot	ther's Name	(First, Middle,	Maiden S	Surname)	
yaı	Menta Menta narked	오	Robert Maltimore Thatcher			Lor	clyn B	oehm La	ake		
, Maryland 21215-0036	nd 2 shou ealth and m 27 is n		19a. Informant's Name/Relationship (Type, Print) Suzanne Nittolo Johnson/daug	1	Mailing Address (\$223 Carri						
Baltimore,	permit. Page 1 and Department of H. Important: If iten any injury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery	Disposition (Name y, crematory or oth easant Ce	er place)	May 20	ate 31,		cation - City or	
Balt	permit. Departi Import any inj	2 1	21. Signature of Funeral Service Licensee M M	01053		Address of Faci					me, P.A.
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	ie death. Do no	ot enter the mode	of dying, such a	s cardiac or	respiratory arr	est,		Approximate Interval Between
1	Medical	8 1	Immediate Cause (Final disease or condition resulting in death) Cardio u								Onset and Death
	Examiner		Due to (or as a c	·	f):						
		iner	Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying b. Due to (or as a condition of the con		f):						
	ecuted and transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last Cardiova Cardiova Due to (or as a company)			ttack					
00/	icate be executed i physician and s the burial-transit	edical E	d. Hyperten	·	····						
200	ertifica ding pl		IF FEMALE: 23c. If yes, outcome of	pregnancy							
POX	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	23b. Was decedent pregnant in the past 12 months? 1	Fetal death	3 Ectopic pre 5 Other (spec					3d. Date of de Month	livery Day Year
7. Ö	s that t gned b	by P	Part II. Other significant conditions contributing to death but	not resulting in	the underlying cal	use given in Par	t I.	23e. Did to	bacco us	e contribute to	the cause of death?
gs,	een sig							1 🗆 Y	∕es 2 [No 3□P	robably 4 🗷 Unknown
Records,	: The law recate has b page 2 sh	Completed						24a. Was a autop perfor 1 Yes	sy med?	prior to death?	topsy findings available completion of cause of
VITA	ician: certifi rector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpetient			26. Place of De	ath (Check	only one)			
> 10	g Physer this eral di	e: To	27. Manner of Death 28a. Date of injury	28b. Tir		. Injury at		ne 5 🗌 Reside 3d. Describe ho			ify)
DIVISION OF	kttending death. ctor: Afte y the fun	Certificate:	1 XXNatural 5 Pending (Month, Day, Y 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury		jury M	work? 1 Yes 2	□No				ral Route Number,
	pital or A ours after eral Dire filled in b		building, etc. (8	Specify)				City or Town	n, State)		
	the Hos hin 24 ho the Fun npleted	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my only one) 3 Certifying Nurse Practioner: To the best of my one	nination and/or	investigation, in my	opinion, death	occurred at t	he time date an	nd place	and due to the	cause(s) and manner stated
	,		29b. Signature and title of certifier			icense number 1067092		2		signed (Month	
	5 %		30. Name and address of person who completed cause of deat Weihan Wang, MD, 15245 Sh			Suite	130,	Rockvil	lle,	MD 208	50
	Stat Registra	٠	31. Date filed (Month, Day, Year) 32. Jegistrar's	Signature	bailes						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 21, 10:42 P M Betty H. Ovington Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 17813 Park Mill Drive Derwood Montgomery 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days January 3, 1933 1 M 2X I Hours 78 Yrs Tennessee 411-46-6045 Director Usual Residence of Decedent shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f Maryland | Montgomery Derwood 1 ☐ Yes 2 🛣 No 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? items 23a Funeral 20855 17813 Park Mill Drive United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 6 þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 72 hours after White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify: 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Research & and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Secretary Development Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname, ျ Cleo Harris Robert Hutcherson permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17813 Park Mill Drive, Derwood, Maryland 20855 Gordon G. Ovington/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of ${\stackrel{\mathsf{Date}}{\operatorname{2011}}}^{\mathsf{Date}}$, 20c. Location - City or Town, State Crematorium, Inc. 1 🗌 Burial 2 🔀 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 Signature of Funeral Service Licenses M01498 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ Coronary Atherosclerosis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and -transit Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Month Day Year Pregnant at time of death Yes 2X No signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Atrial Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown been si Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performe death? certificate 2 🗓 No 2 No Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospita Other: 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) s after death.

I Director; After this ed in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after des To the Funeral Director completed filled in by th 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Contifying Nurse Practioner To the Sest of my knowledge, de dat the time 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year)

10 By

State

Registrar
DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Geoffrey Coleman,

31. Date filed (Mont

D37142

355 Piccard Drive, Suite 100, Rockville, Maryland 20850

May 23, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 22, 2011 6:05 Рм Pizzuti Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Coastal Hospice at the Lake Salisbury Wicomico Social Security Number 6. Sex 1 X M 2 - F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth **Funeral** Months Days New Jersey 93 March Day (ear) 1918 136-16-0490 **Director** Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits Director notified 1 Yes 2 X No Worcester Berlin 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? pe Funeral items 23 318 West Street 21811 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. ŏ ģ 1 Never Married 2 Married 1 X Yes 2 □ No Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10 Excavator Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Salvatore Pizzuti Ida Immediato 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Sharon Witkowski/Daughter 318 West Street, Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date cemetery crematory or other place)
Glendale 1 🔀 Burial 🤰 🗆 Cremation 3 🗆 Removal from State 4 □ Donation 5 □ Other (Specify) May 27,2011 Bloomfield, NJ emetery 22 Name and Address of Facility Caggiano Funeral Home 62 Grove St., Montclair 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death CHRONIC Physician/ DISPLASE disease or condition resulting in death) OBSTRUCTIVE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to for as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of): attending physician for use as the buria Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? 4 Pregnant at time of death g Unknown Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X No 2 🗆 No 1 Tyes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🛣 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 🔀 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at P Hospital or Attending P 124 hours after death.
Funeral Director, After t 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier DO058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21807 33 31. Date filed (Month, Day, Year) State

Registrar
DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Physician 11:04 AM verina anne lav 8 201 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** topkins JOKNS If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F Months 556-98-1880 3 Director GARIA Bul Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Execution must be notified as 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? WSA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces?

1
Yes 2
No 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Guderov 0 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35 3 WAYNO 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 129-2011 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part 1. Enter the diser shock, or heart fail, e Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, only one cause on each line. Immediate Cause (Finat disease or condition resulting in death) Physician ventricular /Medical Due to (or as a consequence of) Examiner cidemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Dulmonary and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical the / the attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed peen a 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has autopsy performed? certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes Inpatient 2 ER/Outpatient 3 DOA Certification: To After thi 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier -00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mary 24ay Physician/ 201°1 2:15PM Pablo Federico Palacios Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4h. City. Town or Location of Death **Examiner** Baltimore Towson Gilchrist Hospice If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days June 7, Year) 920 1 🙀 M 2 🗆 F Months Hours Min Peru Country) 219-35-4043 Director 90 Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits aţ death with the Maryland Director must be notified 1 🗆 Yes 2 🏝 No 28a-f Ellicott City MD Howard 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ö Funeral 23a U.S.A. 21042 3065 Katherine Place ral", or items? Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir Completed by 1 Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: 3 XXWidowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Health Inspector Theatres 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Emma Trelles Pablo Palacios 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3065 Katherine Place Ellicott City, MD 21042 Heidi Miranda Walsh (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State Atlantic Crematory Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) -26-2011 22. Name and Address of Facility Signature of Funeral Service Liceuse Witzke Funeral Homes, Columbia, MD 21045 5555 Twin Knolls Road mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease Approximate Interval Between Onset and Death shock, or heart failure. List or Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Jause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month 5 Other (specify) Pregnant at time of death signed by the a be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown To Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an performed 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 \(\simeg\) Yes Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendia within 24 hours after death. To the Funeral Director: At completed filled in by the fu 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Cectifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. y one) 5-25-1 DO071287 ûte 4105, Baltimore, MO 212 or 6701 Day, Yea 2011 32. Registrar's Signature State 3 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 23 2011 Patricia Giacomo 2:10 A M Pugh Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Towson Baltimore Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign '. Age (In yrs. last birthday)

57 vrs **Funeral** 212-62-6328 1 ... M 2 X F Months Days Hours Min. A(Yenth, 222 Ye17953 Mary Pand **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director be notified 28a-f 1 Yes 2X No Maryland Baltimore Parkville 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a c c must h Funeral 8025 Ridgely Oak Drive 21234 U.S.A. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 6 Completed by 1 Never Married 2 Married ☐ Yes Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White "natural", 3 Wildowed 4 Divorced Year or Dates Medical 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ed other that event, the N Clerk Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f Health and Mental Fitem 27 is marked o other traumatic ever မ Patrick Giacomo Virginia Gaynor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Giacomo / Brother Oakleigh Road Parkville, Maryland 21234 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Durial 2 X Cremation 3 Removal from State Hilltop Service Corp. 5/31/2011 Towson, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of FacilityRuck Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final sician/ disease or condition Medical resulting in death) Due to (or as a sequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. Cause (Disease or iinjury that initiated events burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months Month Day Year Pregnant at time of death Unknown signed by the a Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Ves 2 □ No 3 □ Probably 4 □ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed' death? After this certificate I 2 No 2 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work 1 Natural 5 Pending 1 Yes 2 No Investigation Director: / Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature a 29d. Date signed (Month, Dav. Year) 7104 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KUMAR NO CHARCES ST 4108 32. Registrar's Signature

State

Registrar

31. Date filed (Month, Day,

MAY 3 1 2011

11-03836 Wayne Powell

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene

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Funeral		5. Social Security Number 17. 6. Sex 7. Age (In yrs.		If Under 1 Ye	ear If Under 24Hr	s. 8. Date of Bir	th(MM/DD/YYYY) 9.	Birthplace (State or unk
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5-0036 Identify the same specific of the same spec	2	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's	Usual Occup	ation (Give kind of	work done	16b. Kind of Busine	ss/Industry unk
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21215-00 ould be filed with I Mental Hygiene i marked other i cevent, the Me		17. Father's Name (First, Middle, Last)		unk		•	Maiden Surname)	unk
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MD 2 show lth and N n 27 is r		O.C.M.E. Mary Brewer(Sister)	5 Arbo	or Hil	I Rd. A	nnapolis	,MD,21403 imore, MD	
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Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other ti	ŀ	21 Gignature of Suneral Service licenses the Sirector	22 Nam	e and Addre	ss of Facility	rd 655 W	Raltimo	ra Straat
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Ox 687 sath certific attending		3b. Was decedent pregnant in the past 12 months?	2 Fetal o		Ectopic pregn	ancy	Month	Day Year
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Pulliam Month Physician/ Maize 10:13 4 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 532 LAURENS St. BALTIMORE 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 🗹 F Months MD 218-50-1485 61 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits or 28a-f shov 10b. County 10a. State iral", or items 23a or 28a-f sho Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No BALTIMORE MD 10e. Street and Number 10g. Citizen of What Country? Funeral 21217 AURENS Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 ☑ No 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes Give 3 Widowed 4 Divorced marked other than "nature matic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) SerVICE if Health and Mental Hygiene. Item 27 is marked other that other traumatic event, the A .00K Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MCCARTHY ည KENNETH MCCARTHY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 532 LAURENST. BAHO. MD 21217 DENISE MCCARTHY- DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State le Tro CreMATORY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility 22. Name and Address of APRICE FUNCYAL 3512 Frederick 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Breast Cancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Medical Certificate: To Be Completed by Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 ☑ No Month Pregnant at time of death Other (specify) signed by the at the detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Tyes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 - Nursing Home 5 - Residence 6 - Other (Specify) 1 Yes 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Ai completed filled in by the fu Accident Investigation 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) MS Rijapalne M.D DOUS7-465 5127/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21209. 5-703 Balhmire MO NS Rayapakse MD 2835 Smin M

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4:40 AN ice linton 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Hospita emoria Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min. Country **Director** Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at Director Baltimore 1 Yes 2 🗆 No 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code ö 23a Funeral 21218 USA items ? Was Deces Armed Forces? Yes 2 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married ō 2 Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Black "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) than /Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha arpet l abover Be Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra Balton Palmer E Baltimore, od of Disposition 20b. Place of Disposition (Name of Date 1 KBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 28/2011 Baltimore, MD 4 Donation 5 Other (Specify) March F/H 1101 E. North 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final patocellular Physician/ (ar cinoma 2 Par Medical resulting in death) Due to (or as a consequence of): Examiner morthe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the ass use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death signed by the a d be detached f 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy this certificate has Yes 2 X No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No ᅆ 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred After 1 Natural iniury 5 Pending 2 No 2 Accident
3 Suicide
4 Homicide Investigation hours after death the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined 24 hours a Medical 29a. Certifier 1 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I 3 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) AT2438946C10 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mitra Hasherni, mb 21 union memorial Hospital, 201 East university Parkway, Baltimere, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mitra Hashem), 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Gisele Denise Richard Month May 24. Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1478 Medfield Avenue Baltimore 5 4 1 Social Security Number 7. Age (In vrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days Hours Min. Director Yrs <u>574-24-2263</u> May 8 1943 France Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits MD N/A Baltimore way Yes 2 ☐ No 10e. Street and Number ò 10f. Zip Code must be r 10g. Citizen of What Country? Funeral 1478 Medfield Avenue 21211 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any lipiury or other traumatic event, the Medical Examinar mone. France 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give XX
Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White Completed 3 Widowed 4 XX pivorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Waitress Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೨ Maxime Rene Message Edith Madeleine Roussel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Richard (Daughter) 602 West 38th Street Balto, MD 21211 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial XX Cremation 3 Removal from State Atlantic Crematory 4 Donation 5 Other (Specify) 5/25/2011 Glen Burnie, MD 22. Name and Address of Facility
urgee Henss-Seitz Funeral Home, Falls Road Balto. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final nset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Live Bertal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day the Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaeco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has l e 2 s autopsy page performed certificate Yes 2 4 Be 25. Was case referred to edical 26. Place of Death (Check only one) examiner? Hospital ၉ 1 🗌 Yes 2 10 No Other this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27, Manner of Death Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural Pending 1 ☐ Yes 2 ☐ No Accident neral Director: / Investigation Suicide ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one Signatur 29b. 30. Name and address of ed cause of death (Item 23a) (Ty 31. Date filed (Month, Day, State

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Registrar